The Pedagogical Practices of Clinical Nurse Educators

By

Anita Jennings

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Graduate Department of Curriculum and Teaching at
Ontario Institute for Studies in Education in The University of Toronto.

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Abstract

Clinical practica forms an important component in undergraduate nursing education, which directly involves clinical nurse educators who are primarily involved in teaching student nurses. The purpose of this study was twofold: to theorize the pedagogical practices of clinical nurse educators and to explore the challenges that they encountered while teaching in the clinical arena. These participants taught in undergraduate nursing programs in a large metropolitan city in Ontario, Canada.

Grounded theory methodology forwarded by Charmaz (2010) was used in this study design, and semi-structured interviews were conducted with twelve clinical nurse educator participants. Coding strategies forwarded by Corbin and Strauss (2008, 2015) and Charmaz (2010, 2011), such as constant comparison and theoretical sampling, were used to analyze the data. Study results were further analyzed using a constructivist approach to learning and a critical pedagogical approach to education.

Initially, five main concepts emerged from the data and these concepts were further conceptualized to form the central theory that underpins this study. The substantive theory in this study is: The pedagogical practices of clinical nurse educators and the navigation of constraints
in complex educational institutions. This central theory encompasses the main concepts and includes, the *forms of knowledge* that participants portrayed in their teaching, the *ethics in teaching* that underpin their practice, *varied approaches to teaching* that emerged from the data, and the *context* which describes the teaching milieu.

The results from this study provide a deeper and broader understanding of teaching in the clinical arena. The results also reveal a traditional and progressive approach to teaching in nursing education and how each approach effects curricula development, pedagogy, and the building of teacher-student partnerships.

The results from this study led to two important recommendations: the first, an education program for all nurse educators so as to improve their knowledge and understanding in developing curricula and pedagogy in nursing education; and the second provides a re-conceptualist approach to developing undergraduate nursing curricula and re-conceptualizing of patient safety concepts in the development, design and implementation of nursing curricula in undergraduate nursing programs.
Acknowledgements

First, I want to thank my participants for without them there would be no such project. I would like to thank them for sharing their honest, insightful and sometimes tearful experiences—and more importantly their knowledge of teaching in the clinical arena. I could not have gained these critical insights which enabled me to examine more deeply the issues that emerged from the data. It is they to whom I am first and most sincerely indebted.

I would also like to thank the many professors in the department of Curriculum and Teaching at OISE who encouraged and supported me along the way. Particularly, I would like to thank Profs, Drs. Ruben Gaztambide-Fernandez, Clare Kosnik, Patrick Finessy, Rob Simon, Elizabeth Campbell, and Barrie Bennett for sharing their knowledge and enthusiasm about teaching.

I like to acknowledge and thank my supervisor, Dr. Clare Brett for guiding and supporting me throughout my doctoral journey. I like to thank her for her wise counsel, her guidance, and her unyielding commitment to my learning. Clare’s timely and honest feedback on my academic work was important to my success.

I would also like to thank my dear colleague Brigitte, my dear friend, Nydia and her family without which this journey would be extremely daunting. Thank you for your patience with which you inspired me and for your confidence and conviction in my abilities that you brought into my life. Also, I like to thank Beth for reading and editing my work with patience and timeliness.

I want to thank my readers, for your time and interest in both this project and its broader implications. It is my sincere hope that you find these results useful in your journey in nursing and in your teaching practice.

Lastly, I was inspired by the words of many authors during this journey and include the words of one such author.

Why is teaching more difficult than learning? Not because the teacher must have a larger store of information, and have it always ready. Teaching is more difficult than learning because what teaching calls for is this: To Let Learn.

(Heidegger, 1968. p.15)
## Table of Contents

**Abstract**

<table>
<thead>
<tr>
<th>1.0 Introduction to Study.</th>
<th>Pgs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Situating the inquiry in Context.</td>
<td>1.</td>
</tr>
<tr>
<td>1.1.2. Statistical Information of nurse educators in Canada.</td>
<td></td>
</tr>
<tr>
<td>1.2. Undergraduate Nursing Education.</td>
<td>6.</td>
</tr>
<tr>
<td>1.2.1. Professional education and its purpose.</td>
<td></td>
</tr>
<tr>
<td>1.2.2. Undergraduate nursing education in Canada.</td>
<td></td>
</tr>
<tr>
<td>1.2.3. Undergraduate nursing curriculum in the clinical arena.</td>
<td></td>
</tr>
<tr>
<td>1.2.4. Models of Delivery of Undergraduate nursing curricula.</td>
<td></td>
</tr>
<tr>
<td>1.3. Clinical nurse educators.</td>
<td>10.</td>
</tr>
<tr>
<td>1.3.1 Clinical nurse educators’ role.</td>
<td></td>
</tr>
<tr>
<td>1.3.2. Teaching models found in the clinical arena.</td>
<td></td>
</tr>
<tr>
<td>1.3.3 Professional standards and responsibility of nurse educators.</td>
<td></td>
</tr>
<tr>
<td>1.4. Research questions.</td>
<td>12.</td>
</tr>
<tr>
<td>1.4.1. Significance of study.</td>
<td></td>
</tr>
<tr>
<td>1.5. Situating the researcher.</td>
<td>13.</td>
</tr>
<tr>
<td>Summary of chapter.</td>
<td>19.</td>
</tr>
</tbody>
</table>

**2.0. Grounding the Inquiry in Literature**

Overview of Chapter.

<table>
<thead>
<tr>
<th>2.1 Curricula and Pedagogy in Undergraduate Nursing Education.</th>
<th>20.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1. Classroom Practice Divide.</td>
<td></td>
</tr>
<tr>
<td>2.2. Parallels between Teacher Educators and Nurse Educators.</td>
<td>25.</td>
</tr>
<tr>
<td>2.2.1. Distinction between teacher educators and nurse educators.</td>
<td></td>
</tr>
<tr>
<td>2.2.2 Important differences between classroom and clinical nurse educators.</td>
<td></td>
</tr>
<tr>
<td>2.3 Grounding the inquiry in education literature.</td>
<td>29.</td>
</tr>
<tr>
<td>2.3.1. Curriculum, andragogy and pedagogy.</td>
<td></td>
</tr>
<tr>
<td>2.3.2. Approaches to developing curricula-Broad overview of Tyler’s theory.</td>
<td></td>
</tr>
<tr>
<td>2.3.2.1. Development of Undergraduate Nursing Curricula using Tyler’s approach.</td>
<td></td>
</tr>
<tr>
<td>2.3.2.2. Knowledge claims using Tyler’s approach.</td>
<td></td>
</tr>
<tr>
<td>2.3.2.3. Instruction using Tyler’s approach.</td>
<td></td>
</tr>
<tr>
<td>2.3.3. A Constructivist approach to Education.</td>
<td>36</td>
</tr>
<tr>
<td>2.3.3.1. Broad overview of constructivist theory.</td>
<td></td>
</tr>
<tr>
<td>2.3.3.1.1. Social constructivism.</td>
<td></td>
</tr>
<tr>
<td>2.3.3.1.1. Knowledge claims found in a social constructivist approach.</td>
<td></td>
</tr>
<tr>
<td>2.3.3.2. A social constructivist approach to pedagogy.</td>
<td></td>
</tr>
<tr>
<td>2.4 Theoretical lens used in the study.</td>
<td>41.</td>
</tr>
<tr>
<td>2.4.1. Critical Pedagogy.</td>
<td></td>
</tr>
<tr>
<td>2.4.1.1. Critical pedagogy and instruction.</td>
<td></td>
</tr>
<tr>
<td>2.4.2. Critical pedagogy and Friere.</td>
<td></td>
</tr>
<tr>
<td>Summary of chapter.</td>
<td>49.</td>
</tr>
</tbody>
</table>
3.0. Methods
Overview of Chapter
3.1. Research Questions.
   3.1.2. Justification for using Grounded theory methodology.
3.2. Grounded Theory and its evolution.
   3.2.1. Differences in grounded theory between Glaserian and Revisionist’s approach.
      3.2.1.0. Conceptual orientation.
      3.2.1.1. Literature review.
      3.2.1.2. Analytic measures.
   3.2.2. Grounded theory by Chamaz.
      3.2.2.1. Conceptual orientation.
      3.2.2.2. Analytic tools used in this approach.
   3.2.3. Differences between Charmaz and Strauss and Corbin.
   3.2.4. Theoretical assumptions found in Grounded Theory.
      3.2.4.1. Symbolic Interactionism Paradigm.
3.3. Study Participants.
   3.3.1. Number of participants.
      3.3.1.1. Recruitment strategies of participants.
      3.3.1.2. Strategies for the selection of participants.
   3.3.2. Inclusion criteria.
   3.3.3. Exclusion criteria.
3.4. Data Sources and Methods.
   3.4.1. Location and duration of interviews.
   3.4.2. Interviews.
   3.4.3. Analytic procedures used in study.
      3.4.3.1. Constant comparison.
      3.4.3.2. Theoretical sampling.
      3.4.3.3. Theoretical sensitivity.
      3.4.3.4. Reflexivity.
      3.4.3.5. Memoing.
   3.4.4. Coding methods used in this study.
3.5. Data Management.
3.6. Ethical consideration and ethics approval.
3.7. Rigour.
3.8. Limitation of study.
Summary of chapter.

4.0. Study Participants.
Overview of Chapter.
4.1. Commonality amongst participants.
4.2. Important difference in teaching context.
4.3. The emergence of two groups of participants.
4.4. Teaching in the classroom and teaching in the clinical arena.
   Summary of chapter

Pgs.
50.
51.
58.
60.
68.
68.
69.
72.
73.
74.
77.
79.
80.
### 5.0 Theory Development and Results.

**Overview of Chapter.**

5.0.1. Theory Development process.


5.1. Study Results.

- 5.1.1. The Pedagogical knowledge of participants.
  - 5.1.1.1. Instructional Activities.
  - 5.1.1.2. Clinical Nurse Educators and Knowledge in Action.
  - 5.1.1.3. Teaching milieu.

- 5.1.2. Building Pedagogical Partnerships.
  - 5.1.2.1. Pedagogical partnerships with student nurses.
  - 5.1.2.2. Establishing Professional Boundaries.

- 5.1.3. Ethics in teaching.
  - 5.1.3.1. Personal and Professional values.
  - 5.1.3.2. Balancing the learning needs of students with safe care.
  - 5.1.3.3. Teaching milieu.

- 5.1.4. Learning to teach.
  - 5.1.4.1. Knowledge of teaching.
  - 5.1.4.2. Un-learning in order to teach.

- 5.1.5. The Context.
  - 5.1.5.1. Challenges found in the Curriculum and program.
  - 5.1.5.2. Culture of teaching in Nursing.

5.2. Development of Central concept in this study.

**Summary of Chapter.**

---

### 6. Discussion

**Overview of chapter.**

6.0. The Study’s central concept

6.1- Forms of knowledge portrayed by participants.

- 6.1.1. Knowledge For Practice.
- 6.1.2. Knowledge In Practice.
  - Pedagogical content knowledge.
  - Situated pedagogical knowledge.
  - Tacit knowledge.
  - Embodied knowledge.
  - Experiential knowledge of teaching.
  - Reflection and reflective knowledge of teaching.

6.2. Ethics in teaching.

- Personal and Professional values.
- Ethical Decision Making in Teaching.
- Ethics in Traditional and Progressive approaches to teaching.
- Ineffective teacher and student partnerships and its effect on learning.
- Participants and moral conflict.

6.3. Varied Approach to Teaching.

---

<table>
<thead>
<tr>
<th>5.0 Theory Development and Results.</th>
<th>Pgs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of Chapter.</td>
<td>81.</td>
</tr>
<tr>
<td>5.0.1. Theory Development process.</td>
<td></td>
</tr>
<tr>
<td>5.1. Study Results.</td>
<td></td>
</tr>
<tr>
<td>5.1.1. The Pedagogical knowledge of participants.</td>
<td>85.</td>
</tr>
<tr>
<td>5.1.1.1. Instructional Activities.</td>
<td></td>
</tr>
<tr>
<td>5.1.1.2. Clinical Nurse Educators and Knowledge in Action.</td>
<td></td>
</tr>
<tr>
<td>5.1.1.3. Teaching milieu.</td>
<td></td>
</tr>
<tr>
<td>5.1.2. Building Pedagogical Partnerships.</td>
<td>97.</td>
</tr>
<tr>
<td>5.1.2.1. Pedagogical partnerships with student nurses.</td>
<td></td>
</tr>
<tr>
<td>5.1.2.2. Establishing Professional Boundaries.</td>
<td></td>
</tr>
<tr>
<td>5.1.3. Ethics in teaching.</td>
<td>101.</td>
</tr>
<tr>
<td>5.1.3.1. Personal and Professional values.</td>
<td></td>
</tr>
<tr>
<td>5.1.3.2. Balancing the learning needs of students with safe care.</td>
<td></td>
</tr>
<tr>
<td>5.1.3.3. Teaching milieu.</td>
<td></td>
</tr>
<tr>
<td>5.1.4. Learning to teach.</td>
<td>111.</td>
</tr>
<tr>
<td>5.1.4.1. Knowledge of teaching.</td>
<td></td>
</tr>
<tr>
<td>5.1.4.2. Un-learning in order to teach.</td>
<td></td>
</tr>
<tr>
<td>5.1.5. The Context.</td>
<td>117.</td>
</tr>
<tr>
<td>5.1.5.1. Challenges found in the Curriculum and program.</td>
<td></td>
</tr>
<tr>
<td>5.1.5.2. Culture of teaching in Nursing.</td>
<td></td>
</tr>
<tr>
<td>5.2. Development of Central concept in this study.</td>
<td>127.</td>
</tr>
<tr>
<td>Summary of Chapter.</td>
<td>129.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of chapter.</td>
</tr>
<tr>
<td>6.0. The Study’s central concept</td>
</tr>
<tr>
<td>6.1- Forms of knowledge portrayed by participants.</td>
</tr>
<tr>
<td>6.1.1. Knowledge For Practice.</td>
</tr>
<tr>
<td>6.1.2. Knowledge In Practice.</td>
</tr>
<tr>
<td>Pedagogical content knowledge.</td>
</tr>
<tr>
<td>Situated pedagogical knowledge.</td>
</tr>
<tr>
<td>Tacit knowledge.</td>
</tr>
<tr>
<td>Embodied knowledge.</td>
</tr>
<tr>
<td>Experiential knowledge of teaching.</td>
</tr>
<tr>
<td>Reflection and reflective knowledge of teaching.</td>
</tr>
<tr>
<td>6.2. Ethics in teaching.</td>
</tr>
<tr>
<td>Personal and Professional values.</td>
</tr>
<tr>
<td>Ethical Decision Making in Teaching.</td>
</tr>
<tr>
<td>Ethics in Traditional and Progressive approaches to teaching.</td>
</tr>
<tr>
<td>Ineffective teacher and student partnerships and its effect on learning.</td>
</tr>
<tr>
<td>Participants and moral conflict.</td>
</tr>
<tr>
<td>6.3. Varied Approach to Teaching.</td>
</tr>
</tbody>
</table>
6.3.1. Impact of Tyler’s approach in Undergraduate Nursing Curricula
   Impact of Tyler’s approach to instruction in undergraduate nursing education.
   Impact of a Tyler’s approach on teacher and student partnership.

6.3.2. Participants use of a Re-conceptualists approach.
   Participants approach to instruction using a re-conceptualist’s lens.
   Participants approach to curriculum using a re-conceptualist’s lens.
   Participants approach to building a teacher and student partnership using a re-conceptualist’s lens.

6.4. The Context.
   The Hidden curriculum in nursing education.
   Hegemony in nursing education.

Summary of Chapter.

7.0 Conclusion, Implications and Recommendations
Overview of Chapter.

7.0. Implications of study results.
   7.0.1. Nurse educators.
   7.0.2. Nurse administrators in nursing education.
   7.0.3. Implications for accrediting body and policy makers.

7.1. Recommendations.
   7.1.0. An education program for nurse educators.
   7.1.1. A Re-conceptualists approach to developing undergraduate nursing curricula.
          Re-conceptualizing patient safety in curricula development in nursing education.
          A re-conceptual approach to instruction in nursing education.

7.2. Research in nursing education.
Overall Conclusion of this Study.

8. References.

9. Appendices.
   9.1. Information letter to participants.
   9.2. Information Letter and Informed Consent form for participants.
   9.3. Sample of interview guide.
Chapter 1.0 Introduction to Study

Clinical practica are an essential component in undergraduate nursing education, and nurse instructors are primarily involved in teaching student nurses in the clinical arena. Clinical instruction is a pedagogical process (Fowler, 1996; Lyth, 2000; Severinsson, 1995), during which the clinical nurse instructor instructs and guides student nurses to carry out nursing practices in an effective way and with a caring manner. On reviewing the nursing education literature about teaching in the clinical arena, I found a number of studies that described the lived experiences of nurse educators and clinical nurse instructors¹ (Fanutti, 1993; Kramer, 1996; McDonald, 2004; Pauling, 2006; Testut, 2013). However, while nurse researcher Toornstra (1993) identified the professional development requirements of nurse educators, none of these studies have examined in-depth the teaching practices of nurse educators in the clinical arena or their contribution to student learning.

The purpose of this study is twofold: to theorize the pedagogical practices of clinical nurse educators and to explore the challenges that they encounter while teaching in the clinical arena. To investigate these issues, I utilize a grounded theory methodology introduced by Charmaz (1990, 2010). I interviewed twelve clinical nurse educator participants; each participant taught in undergraduate degree programs in nursing. Results from this study will inform an important yet missing element in nursing education literature.

This chapter consist of four sub-sections. First, I provide a brief review of the education preparation of nurse educators and then provide a broad overview of the undergraduate nursing curriculum in order to locate the study within a broader education context in nursing. I introduce the two research questions used in this study. At the end of this chapter, I situate myself and briefly introduce my theoretical assumptions that guided me in conducting this study.

1.1. Situating the Inquiry in Context

In this sub-section, I provide a brief historical review of the education preparation of nurse educators, and some current statistical information on this group in Canada as a context for this study.

¹ In this study, I use the terms “clinical nurse educator” and “clinical nurse instructor” interchangeably, as both terms are used interchangeably in both the clinical arena and the nursing literature.
1.1.1. Historical Review of Education Preparation of Nurse Educators

Graduate programs in nursing began around 1861 in the United States. In 1899, Teacher’s College at Columbia University in New York started one of the earliest doctoral programs for nurses. Graduate education in nursing in Canada, and particularly the development of doctoral education in nursing, lagged behind the development and expansion of graduate nursing programs in the United States. Also, the design of doctoral nursing programs in Canada was influenced by those from the United States (Wood, Giovannetti, & Ross-Kerr, 2004). Similarly, the required qualifications to teach in undergraduate and graduate nursing programs in Canada are comparable to credentials required to teach nursing in similar programs in the United States. Therefore, I utilize literature on the education preparation of nurse educators in the United States to describe the similar education preparation of nurse educators in Canada.

In 1969, the American Nurses Association (ANA), a national body of nurse professionals, determined that there needed to be a more disciplined focus on developing a theoretical knowledge of nursing, and moved away from a focus on developing educational and administrative knowledge of nursing. The ANA concluded that a nurse prepared at a master’s level should practice at an advanced clinical role at the bedside, whereas a doctoral degree was an appropriate and desired credential for a nurse educator (Princeton, 1992; Young, 1999). Previously, nurses prepared at a master’s level taught in both undergraduate and graduate nursing programs.

Parietti (1990) describes the historical evolution of doctoral education in nursing as occurring in three phases—the education phase, a nurse scientist phase, and the current phase of innovation. During the education phase, nurse educators were prepared to instruct and develop curricula for undergraduate and graduate nursing programs. Also, graduates from nursing education programs conducted research relevant to teaching and curricular development. For instance, nurse graduates from these programs recommended that a Bachelor of Science (BScN) was necessary entry into practice for all nursing students. At the same time, nurses in leadership positions in hospitals and in academic organizations recognized changes in the health of the population and ascertained that student nurses should be better prepared. A shift in the education preparation of student nurses entering practice began to occur. In most jurisdictions in Canada and approximately fifteen years ago, a BSc in nursing was determined as the required credential to practice nursing.
During the second phase in the evolution of doctoral education in nursing (1970s approximately), the focus changed and graduate nurses were prepared as nurse scientists (Parietti, 1990). These programs focused on preparing nurse researchers who could advance nursing knowledge and practice, and build a critical mass of nurse researchers to develop doctoral programs. Doctoral candidates in nursing focused on honing their research skills and developing an understanding of both the theory and science of the discipline. In Canada, the University of Alberta launched the first PhD program in nursing in 1991(Wood et al., 2004).

I suggest that this change in the development of PhD programs in nursing had profound implications for nurse educators. It specifically impacted the education preparation of nurse educators, altering their knowledge and expertise in developing nursing curricula and pedagogy. Also, these changes were accompanied by a decrease in funding to programs that prepared nurse educators, which may have exacerbated the lack of current research specifically examining nursing education. On reviewing recent research in the nursing literature, I found a plethora of studies related to the practice of nursing and only a few studies related to nursing pedagogy; some of the more relevant studies in nursing education are included in this thesis.

Subsequently, nurse researchers found that changes to doctoral programs in nursing had a negative impact on teaching of nursing. For instance, Young (1999) conducted a phenomenological study that examined the lived experiences of nurse educators during their first two years of teaching nursing in the United States. Fourteen nurse educators participated: eight had completed master’s degrees and six had received their doctoral degrees in nursing. The education qualifications of the participants reflect the current state of the education preparation for nurse educators. Most of the participants taught in undergraduate and graduate programs and reflected the similar arrangement of nurse educators teaching in Canada. However, none of the participants had taught in the clinical arena. As well, the results revealed that none of the participants had received formal education in teaching or had been prepared for actual teaching practice and these participants reported many challenges in their teaching practice. Young concluded that nurse educators who had completed a doctoral degree needed more pedagogical preparation to teach nursing.

In the current phase in the evolution of doctoral education in nursing (Parietti, 1990), the focus of doctoral education remains on innovation in nursing. For instance, a number of studies published recently focus on developing simulation in nursing (Norman, Dore, & Grierson, 2012;
Shearer, 2013) and developing nursing courses to be delivered online (McIntyre, McDonald, & Racine, 2013; Russell, 2015; Smith, Passmore & Faught, 2009). However, certain nurse scholars have begun re-evaluating the approach to doctoral education for nurse educators. Nurse scholars (Benner, 1993; Diekelmann, 1997, 2004, 2005; Ironside, 2003, 2004, 2005b; Stokes, 2007; Tanner, 2007a; and Walker, 2009) have advocated for changes in doctoral preparation of nurse educators. Also, nurse educators such as Allen (2010), Kelly (2002), Princeton (1992), and Stanley and Dougherty (2010) have joined nurse scholars in supporting the call for curricula changes in the doctoral preparation of nurse educators.

The evolution in the doctoral preparation of nurse educators reflects larger socio-political conditions of the time, as similar changes have occurred in doctoral programs in other disciplines. Prior (1965) states that the expression of

astonishment and incredulity at the state of affairs which allows
college teaching to remain one profession which one may enter without any
direct instruction...and the indifference to good teaching as a basis for
promotion on the part of university administrators, are laid at the door of the
graduate school because of its sponsorship of a doctorate towards research. (p. 39)

The education preparation of nurse educators is similar to that found in other health care disciplines. Currently, most graduates from doctoral programs in nursing are hired into teaching positions in graduate and undergraduate programs in Canada (Pringle, Green, & Johnson, 2004). Also, most doctoral graduates tend to focus on research in nursing practice and see teaching as a lesser priority. Overall from examining the nursing education literature, it seems that most nurse educators do not possess prior pedagogical education and instead learn to teach on the job (Diekelmann, 1997, 2004; Dinkleman, Margolis, & Sikkenga, 2006; Fanutti, 1993; Scanlan, 1996). I address problems associated with learning to teach on the job in more depth in the “Discussion” chapter.

1.1.2. Statistical Information of Nurse Educators in Canada

The need for qualified nurse educators to teach in classrooms and in the clinical arena is an urgent and ongoing issue in Canada. A report titled Nursing Education in Canada: Historical Review and Current Capacity (2004) revealed that sixty percent of nursing schools reported having insufficient qualified nursing faculty to teach nursing (Pringle, Green, & Johnson, 2004). Nursing schools at the time were seeking to recruit one hundred and seventy-six nurse educators
with a master’s or a doctoral (preferred) level of education to fill these positions. The preferred credential to teach in most nursing programs remains a doctorate in nursing.

In 2014, the Canadian Association of Schools of Nursing (CASN), a national professional body of nurse educators, conducted a survey questionnaire (2012–2013). The data revealed a chronic shortage of qualified nurse educators needed for teaching at undergraduate and graduate programs in order to maintain the current enrollment of nursing students. Furthermore, 40% of permanent nursing faculty were fifty-five years of age or older and 20% of permanent nursing faculty (476 of 2,381) were eligible to retire. At the same time, student enrollment in nursing programs had increased steadily (a 2.4% increase from 2012) and surpassed 9,000 graduate nurses per year. The data revealed an “imminent shortage of qualified faculty if current entry-to-practice enrolments are maintained” (CASN, 2012–2013, p. 17). Additionally, nursing schools reported a 3.2% vacancy rate (73 empty full-time teaching positions) during the same time period. At the same time, schools of nursing reported a projected need to hire approximately two hundred and twenty-four full-time nurse educators. The main reasons for these employment vacancies are the lack of adequately prepared faculty, workload issues, and inadequate compensation for nurse educators (Rukholm et al., 2005). In addition, the data revealed that only 27.9% (2,381 of the 8,519) of nurse educators taught full-time and were permanently employed in schools of nursing. The remaining complement of nurse educators consisted of contract and sessional nurse instructors.

The majority of clinical nurse educators are hired on a contract and/or sessional basis and they form a large and essential component of the teaching team in nursing. However, their responses were not included in the survey. Perhaps, as most clinical nurse instructors are hired on a contractual basis, they were not available, or perhaps their input was not sought as they were seen as temporary and thus not considered members of the teaching team in nursing education programs.

Although the CASN report (2014) stated an urgent need for nurse educators with doctoral preparation, the authors of this report did not identify or recommend the actual education preparation of nurse educators. Due to the acute shortage of nurse educators with doctoral preparation, nurse educators with master’s degrees in nursing have been hired to teach full-time in some undergraduate nursing programs. The data also revealed that 14.9% of nurse educators (345 permanent full-time faculty members) were engaged in academic upgrading programs.
Respondents (40.4%) indicated they were enrolled in master’s programs while 50.9% of respondents were enrolled in doctoral programs at home and abroad. However, the results did not reveal whether students studied how to develop curricula and pedagogy in those academic upgrading programs, nor how these upgrading programs impacted their teaching. In this study, I explore how participants learned to teach, their knowledge of teaching as revealed in their practice, and the factors that enhanced or inhibited their teaching in the clinical arena.

1.2. Undergraduate Nursing Education

In this section, I first conceptualize the purpose of professional education, provide a broad overview of the undergraduate nursing curricula including the curriculum in the clinical arena and focus specifically on the role of a clinical nurse educator and teaching in the clinical setting in order to further situate this study.

1.2.1. Professional Education and Its Purpose

Professional disciplines in health education such as nursing and medicine share some unique qualities. Shulman (1998) describes how professional education is characterized by the following attributes:

[T]he obligation of service to others...understanding of a scholarly or theoretical kind; a domain of skilled performance or practice; the exercise of judgment under conditions of unavoidable uncertainty; the need for learning from experience as theory and practice interact; and a professional community to monitor quality and aggregate knowledge.

(p. 516)

Shulman’s description of the purpose of education for professionals relates to many disciplines, such as law, teaching, and nursing. He not only describes the purpose of nursing education but also outlines some issues that nurse educators should consider in developing nursing curricula and educating student nurses. Two important points are nested in this quote, the service to others and the type of knowledge required by the professional in order to meet their obligation. Nursing consists of a theoretical aspect, the science that guides the practitioner, and the art, the actual practice of nursing. The importance of both aspects in nursing is further revealed in the thoughts and actions of participants in this study.

Most nurse scholars’ state that nursing is primarily a practice discipline; that the theoretical aspect of nursing comes to meaningful expression as an embodied practice (Benner, 1993; Casey, 1996; Holmes & Warelow, 2000: Walker, 2009). Additionally, the public view of
the nursing profession is “based on higher education, the service ethic” (Casey, 1996, p. 115); a particular body of knowledge and autonomy of practice. Nursing curricula includes theoretical and practical applications of knowledge, judgment, and decision making in the provision of patient care.

1.2.2. Undergraduate Nursing Education in Canada

The purpose of an undergraduate nursing education is to prepare student nurses to think critically, and to act safely and independently (Fowler, 1996; Lofmark, Carlsson, & Wikblad, 2001; Lofmark & Wikblad, 2001; Nolan, 1998). I found that the meaning of the phrase “to think critically” varied in both the nursing literature (Chan, 2013; Perez et al., 2015) and how it was conceptualised by study participants. In this study, I use a critical pedagogical approach to examine what the notion of “thinking critically” means to the participants in their teaching practice and describe this approach in detail in the Literature Review chapter.

Undergraduate nursing curricula consist of theoretical and practice components and in the practice courses, student nurses learn to care for individuals of diverse ages and in a variety of clinical settings. Students learn about maintaining the health and wellness of individuals and how to care for them in the context of health, wellness, and illness. In addition, student nurses enroll in approximately two to four electives in liberal art courses or courses in departments outside their home school in order to draw upon diverse knowledge and ways of thinking in their development as a professional. In most nursing programs nurse educators are involved in teaching courses such as nursing theory, anatomy, pathophysiology, pharmacology and nursing practice etc. However, in some schools of nursing courses such as anatomy, physiology etc. are taught by educators outside the department. Also, the sequencing and implementation of core nursing concepts in the curriculum varies across programs.

Some nurse educators describe undergraduate nursing curriculum as focused solely on illness, a behaviourist model with authoritarian educational practices that does not reflect the caring aspect of nursing (Ironside, 2001, 2003, 2004, 2005b; Mawn & Reece, 2000; Rush, Quellet, & Wasson, 1991; Tanner, 2007b; Webber, 2002). A behaviourist or traditional approach to education was pervasive in the 1930-1940’s and was adopted by many health disciplines including nursing. This traditional approach to education is mostly associated with a Tylerian view (Giroux, Penna, & Pinar, 1981) of teaching practice. In this study, I describe the Tylerian approach to curricula development and pedagogy in nursing as it emerged as an important theme.
in the results. I contrast this approach with the more progressive approach to curriculum development and pedagogy displayed by the participants. A Tylerian approach to curriculum development focuses on pre-specified learning objectives in determining the type and amount of content that is taught and on the instructional methods used in the course. Also, course outcomes tend to focus on the acquisition of information rather than on situated and contextualized understanding. The main focus in this model is on learning that is defined as “change, behaviorally observable and improvement” (Giroux et al., p. 89) and on a transmission form of teaching. The learner is assumed to be a passive recipient who collects and memorizes information. I describe a traditionalist approach to education in more detail in the “Literature Review” and “Discussion” chapters of this thesis.

1.2.3. Undergraduate Nursing Curriculum in the Clinical Arena

The purpose of a practicum is to enable students to integrate concepts taught in the classroom in practice, familiarize themselves with the practice environments thereby enabling them to become practitioners of nursing ((Bourgeois, Drayton, & Brown, 2011; Franklin, 2013; Rodgers, & Jenkins, 2010). As students’ progress through the four years in a traditional nursing program, they learn to care for patients with increasing acuity as they gain better understanding of the complexity of many diseases. For instance, students in the first year in a traditional program learn to provide for the personal hygiene, mobility, and nutritional needs of the patients; whereas students in the final year have learned to additionally care for the patients’ physical, mental, and psychosocial well-being. In addition, student nurses in the final year of the program need to demonstrate their ability to individually manage and care for approximately two to four patients concurrently.

In most traditional four-year undergraduate nursing programs, student nurses participate in a practicum in each of the four years. The practicum varies in length, from approximately fifty hours in the first year to approximately two hundred and fifty hours to three hundred hours per year in each of the remaining three years and occurs in a variety of settings such as acute care hospitals, long-term care, complex-care facilities, and community agencies.

Nursing as a professional discipline involves teaching substantial amounts of nursing theory so students can effectively care for their patients (Shulman, 1998, 2005). Nursing education in the clinical arena includes the integration of theoretical concepts into practice, the application of knowledge, the experiential conceptualization of knowledge, and socialization into
the profession. Knowledge application includes procedural, experiential and embodied knowledge. For instance, when a student performs a skill such as naso-gastric insertion (tube insertion through nose for feeding) for the first time, she/he uses procedural knowledge. As the student continues to perform the task over time, she/he begins to rely on her/his sense of touch and feel of a successful insertion. Knowledge of a successful tube insertion includes cognitive knowledge as well as experientially grounded knowledge of the body. Experiential knowledge involves drawing upon experiences that have personal reality and meaning for the learner. The student nurse draws upon her/his personal learning from her/his clinical experience and builds this knowledge and understanding of nursing practice. For instance, in the above-mentioned example, the student nurse, by ensuring that the patient is comfortable prior to tube insertion, ensures that she/he is able to successfully complete the procedure. The experience informs learning and impacts the student’s practice.

However, not all clinical experiences that student nurses are exposed to may actually contribute to student learning, as we will see in the “Results” chapter of this thesis.

1.2.4. Models of Delivery of Undergraduate Nursing Curriculum

In this study, clinical nurse educator participants taught in both traditional four-year degree and accelerated degree programs, in both college and university institutions. The nursing curriculum is similar in both types of degree programs; however, in the accelerated degree programs students enter the nursing program with an undergraduate degree. I provide a brief review of the models of delivery of undergraduate nursing programs in Ontario, Canada, to further situate the teaching context.

Dale (2007) described a variety of models and designs in explaining structural elements of schools of nursing and collaborative nursing programs in Ontario, Canada. In some cases, colleges and universities partner to offer the same undergraduate nursing degree, while in other instances the university alone offers a nursing degree. Collaborative nursing programs in Ontario are described as following three designs-integrated, hybrid, or an articulated design-where nurse educators may or may not share teaching assignments (Dale, 2007). On examining each design, I found many differences within and amongst the models. Each model seems to influence the composition of the kinds of nurse educators teaching in each education institution.

In addition, based on my observations and anecdotal accounts of other nurse educators in the field, I found a few differences between nurse educators teaching undergraduate nursing in a
university setting and nurse educators teaching in a college setting. One main difference were the criteria and processes for hiring nurse educators in each institution. The purpose and context of the education institution itself seemed to influence which qualifications were required for hiring nurse educators. It seems that most nurse educators teaching in a university setting had completed a doctoral degree; whereas most nurse educators teaching in the college sector had completed a master’s degree. Secondly, most nurse educators teaching at the university tended to teach mainly in the classroom, whereas nurse educators teaching in the college sector tended to teach in both the classroom and the clinical arena. Despite these differences, the purpose of a nurse educator in undergraduate nursing education remains the same: to prepare student nurses to learn to provide safe, ethical, and culturally competent care to individual patients and/or a community of clients (CNO, Professional Standards, 2002).

1.3. Clinical Nurse Educators

Clinical supervision is an essential element in nursing education as it enables learners to consolidate their knowledge and facilitate professional growth (Fowler, 1996; Franklin, 2013; Glatthorn, 1984; Pauling, 2006; Severinsson, 1995). In nursing, supervision is defined as a “formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their practice and enhance consumer protection and safety of care in complex clinical situations” (Lyth, 2000, p. 15).

The clinical nurse educator in most cases is a seasoned nurse with knowledge and/or expertise in clinical or administrative nursing (Fowler, 1996; Severinsson, 1995). In this study, all twelve nurse educator participants had been practicing nurses for many years and I have described some important characteristics of these participants in the section Study Participants.

1.3.1. Clinical Nurse Educators’ Role

Clinical teaching is embedded in a complex mixture of knowledge, practice, and institutionalized expectation and responsibility (Ewashen & Lane, 2007). Some of the main functions of a clinical nurse educator’s role are as follows: to guide students in integrating theoretical concepts in practice; to guide students in planning care for the patient; to instruct

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2 The terms “clinical supervision” and “clinical instruction” are used interchangeably in practice. Also, this definition closely resembles the definition adopted by Canadian nursing regulatory bodies and identifies expectations and accountabilities of a clinical educator. I use the term “clinical instruction” in this thesis.
students in learning skills and procedures; and to engage students to critically think about their nursing practice in planning how they care for their patients.

Clinical nurse educators need to have a good grasp of many forms of knowledge, such as disciplinary content knowledge, theoretical aspects that underpin teaching and learning, an understanding of how students learn, and knowledge of classroom management in order to become effective clinical nurse instructors. Boyer (1990) adds that educators must be “well informed and steeped in the knowledge of their fields ... [so they can] build bridges between their (teacher’s) understanding and the student’s learning” (p. 23).

I argue that teaching in the clinical arena also requires particular forms of knowledge, expertise, and reasoning. The clinical nurse educators’ dual focus on students and patients adds to the complexity of teaching in the clinical arena as the clinical nurse educator has dual responsibilities to both the student nurses and to patients whose care they deliver. The data from this study reveals the particular forms of knowledge portrayed by the participants, the ethics that underpin their teaching practice, and some of the challenges that they encountered while teaching in the clinical arena. The results also reveal the location of the clinical instructor within the hierarchy found in the nursing department and is further explained in the “Discussion” chapter.

1.3.2. Teaching Models Found in the Clinical Arena

The two most common types of teaching models found in the clinical arena are direct instruction of a small group and a preceptor model (Bourgeois et al., 2011; Franklin, 2013). In the direct instruction model, the clinical nurse instructor is directly involved in teaching a group of four to eight students. The nurse instructor guides the students in their learning to provide care as this is the student nurses’ first direct exposure to patients and the health care system. In the preceptor model, the student works directly with a nurse currently in practice and is indirectly supervised by a nurse educator (Franklin, 2013). While some undergraduate nursing programs use a direct instruction model throughout all four years of the program, others use a preceptor model during that latter phase of the program (the history behind these two models is beyond the scope of this study and will therefore not be further discussed).

In selecting participants for this study, I only included participants with direct teaching responsibilities in the clinical arena and excluded nurse instructors involved with indirect supervision in order to focus more clearly on the issues related specifically to direct instructional experiences of nurse instructors in the clinical arena. Also, the preceptor model consists of many
variations and poses different challenges. I describe in detail the selection process of participants in the “Methodology” section.

1.3.3. Professional Standards and Responsibility of Nurse Educators

Nurses practice in a variety of roles, such as direct patient care providers, nurse educators, managers, and researchers. The College of Nurses of Ontario—the regulatory body for nurses in the province—states that nurses must demonstrate safe, effective, and ethical nursing care to their clients (Professional Standards, 2002). Also, every nurse regardless of her/his role has a primary responsibility to ensure safe care to patients. Additionally, the College of Nurses states that nurse educators must “place the safety and well-being of their clients above all other objectives including fulfilling educational obligations” (Practice Guideline, 2009, p. 3).

Although the regulatory body clearly emphasizes that the primary responsibility of a nurse educator is the safety and well-being of the client, it does not address the constraints placed on clinical nurse educators by the educational institution or clinical facilities where student nurses practice, and thus does not provide guidance when these different sets of goals come into conflict. In this study, I explore the constraints that participants encountered navigating the educational requirements while balancing the responsibilities of their role and instructing students in the provision of safe patient care.

1.4. Research Questions

In grounded theory methodology, the researcher begins the study by posing broad questions and continues to develop and frame questions during the data collection process in order to delve more deeply into emerging issues (Corbin & Strauss, 2015; Charmaz, 2010). The two broad research questions in this study were as follows:

1. How do clinical nurse educators approach teaching undergraduate nursing students in the clinical arena?

2. What challenges do clinical nurse educators encounter while instructing undergraduate nursing students in the clinical arena?

1.4.1. Significance of This Study

This study contributes to nursing education in four significant ways. First, this study describes in detail the knowledge that seasoned nurse educators’ bring to their teaching practice and, to date, there are no other studies describing the forms of knowledge that nurse educators bring to their teaching. Second, the results highlight the complexity involved in instructing
student nurses in the clinical arena, an aspect that is missing in the literature in nursing education. Third, the results detail the contribution of seasoned clinical nurse educators’ to student learning. Fourth, the results reflect the impact of curricula and program decisions on the teaching practice of clinical nurse educators and on student learning, information that can help inform the future development of nursing curricula and nursing education programs.

1.5. Situating the Researcher

I had been a nurse clinician for over twenty years prior to becoming a nurse educator. I began my teaching career as a nurse instructor teaching undergraduate nursing students in the clinical environment. I currently teach in an undergraduate Bachelor of Nursing (BScN) collaborative program in a large metropolitan city, in Canada. The collaborative program is a partnership between one university and two colleges; I teach at the college site in the classroom, laboratory, and clinical arena.

On joining the collaborative nursing program, I thought that my teaching experiences as a nurse educator in critical care nursing would enable me to teach student nurses. I soon realized that knowledge of nursing alone was insufficient for teaching. I felt unprepared even though I had completed course work in adult education in my graduate nursing program. For instance, while teaching student nurses about the principles of enteral nutrition (tube feeding into the stomach and intestines); I remember seeing the puzzled look on their faces. I realized that I should have introduced the essential rationale surrounding the conditions for and use of enteral nutrition more slowly. I realized that I needed to understand in more depth issues surrounding curriculum theory and pedagogy in order to meet the needs of varied student audiences.

Reflecting on my unpreparedness, I thought about teachers who inspired me. Also, I consulted and spoke with many colleagues, both nursing and non-nursing educators. I discovered that while some of my nurse educator colleagues struggled with similar issues, others provided strategies that they had learned through trial and error.

As I reflect on my journey of learning to teach before enrolling in my current academic program, I recollect that I too used many sources to inform my teaching. There were many instances in my journey as a nurse educator where I engaged in examining and re-examining my values in relation to teaching, caring, and nursing.

Furthermore, on reflecting on my journey as a woman, an immigrant, nurse, teacher, and student, I find Pinar’s (2004, 2012) explanation of curriculum a meaningful conceptualization.
Pinar defines curriculum as *currere* or autobiographical journey where one “seeks to understand the contribution academic studies makes to one understanding of his or her life and how both are imbricated in society, politics and culture” (Pinar, 2012, p. 36). *Currere* involves an iterative process of self-understanding, looking back on one’s lived experience in order to transform the future with its many possibilities and where one becomes mobilized and engages with others in the social reconstruction of a public sphere (p. 37). What I found most compelling was that the holistic conception of *currere* embodied the varied elements of teaching practice in nursing, and it enabled me to take a more reflective stance on these experiences and examine these issues more broadly.

I first describe two moments in my teaching experience that caused me to stop, ponder, and reflect on my observations and experiences. I then use Pinar’s (2012) framework on self-reflexivity to analyze both situations.

In examining my student journey in both nursing and teaching, two moments come into sharp focus. The first moment involves my experience as a graduate student in a nursing program in a metropolitan city, in Canada. The second moment includes a teaching experience in the clinical arena while employed as a nurse educator in a collaborative university-college program.

**Critical Moment 1.5.1. My experience as a graduate student in nursing**

I had enrolled in a graduate program in nursing to complete my master’s in nursing. At the time I had been practicing nursing for many years, had had a variety of rich nursing experiences, and had worked as a nurse in Canada and abroad.

The event occurred in a research course, a required course in graduate nursing programs. The course was well attended by graduate student nurses. There were approximately seventy students in this research class and most of the students had been practicing nursing for many years. The course was taught by a well-known nurse researcher who had taught this course for many years. The classroom was full with students chatting, some were reading as we waited to receive feedback on the assignment. Before returning the assignment to the class, the professor asked the two teaching assistants to write on the blackboard each mistake each student made on the assignment. The assistants wrote until the blackboard was covered with words and there was no more space to write. The activity lasted for approximately two hours and the students read in silence as each mistake filled the air. Although many words and phrases found in the errors were similar, each mistake was individually written on the blackboard.
Although this event happened approximately twelve years ago, I still remember it quite vividly. While some of my fellow students sat in silence, I remember feeling shocked and dismayed. I remember engaging in many conversations with my classmates during and after the class. My student colleagues displayed many emotions that ranged from anger to disbelief to humiliation. I began to ponder on the reasoning behind this particular teacher’s action and approach. I began to examine more closely how nurse educators taught. I compared and contrasted teaching methods used by different professors and instruction across disciplines. I observed, listened, and read more deeply about learning and teaching.

**Critical Moment 1.5.2. My experience as a clinical nurse educator**

The second moment involves a teaching experience in the clinical arena. I had completed my master’s in nursing and had been teaching undergraduate nursing students for approximately two years. I was new to the academic environment. I was a clinical instructor on a medical unit.

I was instructing a group of eight students in an acute medical unit during the winter term. I had met my group of students at the beginning of the term and had begun working with each student in developing her/his knowledge and skills about caring for a person. The patients on the unit had varied problems from acute respiratory distress to more chronic health problems such as diabetes and cardiac disease. Each student was responsible for one patient during her/his seven-hour shift. On this occasion, one of the students informed me that the patient was to receive a nebulized (inhaled medication via a device) treatment to relieve his breathing problems. The student had correct information about the drug but was unsure of administering the medication. On assessing the patient, I felt that the regular puffer form of the same medication would suffice and that the patient did not require nebulized treatment (The patient’s condition would determine the method of administration. The method of administration could affect the efficacy of the medication). Also, isolation precautions as per the guidelines for administering nebulized treatments were absent. I realized at the time that many other patients on the unit were also receiving nebulized treatment. Curious as to the reasons for nebulization, I spoke with the in-charge nurse and raised my concern. I received a hostile reply from that nurse. A few days later I received a message from the lead teacher in the nursing program. Although the lead teacher agreed with my concern and action, the teacher suggested that I not raise the issue at the facility again. I remember raising the issue at subsequent practice meetings held during the term and on curriculum review days. My concerns were ignored and dismissed. I was concerned for
the following reasons. The method of administration of this drug was not suitable for this patient and this method could potentially spread airborne infections to others in the vicinity. The dissonance between concepts taught in the classroom and the reality in practice disturbed me, as student nurses require clear rationales in order to learn and practice safe medication administration. I further felt that legitimate concerns and issues in practice were not considered important by nursing faculty in my program.

I believe that learning depends on concrete experiences and that reflection on the meaning of the event leads to further growth in teaching experience (Ayers, 1988). By providing a rationale for how best to administer the medication, I intended that students would learn to think critically about their actions, raise questions and concerns, and feel comfortable in challenging senior nursing staff and, more importantly, not follow commands blindly. Clearly, most student nurses are unsure of their knowledge and reasoning in nursing and prefer to go along with the staff nurses’ decisions even in situations where the student nurse may be quite correct (Lofmark, Carlsson, & Wikblad, 2001). This experience however, made me think that it was important to demonstrate to student nurses the need for becoming an advocate for oneself and in doing so, one becomes a better advocate for one’s patients.

On examining both situations, some commonalities emerged. Each experience caused me to stop, think, and ponder, and to examine the issues more deeply. I found using Pinar’s (2004, 2012) framework on self-reflexivity to examine both situations very helpful. First, I describe the framework and then examine both situations using the framework.

Pinar (2012) suggests that teachers engage in reflecting on their teaching experiences in order to improve their teaching and build their knowledge of teaching. Pinar (2012) describes four steps or moments in currere: the regressive, progressive, analytical, and synthetical. These moments include temporal and cognitive thoughts about one’s educational experience. In the regressive step, the individual examines her/his lived experience as a data source (p. 36). In the progressive step, one looks forward and imagines possible futures. In the analytical step, the student examines both the past and present by “bracketing” one’s experience. In the synthetical step, one re-enters the currently lived present state. The steps are not linear but circular, with each step signalling the many influences on the individual and on her/his understanding of curriculum.
I realized that I had begun examining both critical events using the regressive and analytic steps described by Pinar (2012). Both scenarios enabled me to examine more deeply and consider the teaching practice of many nurse educators, the manner of teaching in nursing, the relationship between teachers and students more broadly, and the effect of lack of effective teacher-student relationships on student learning. Also, these experiences enabled me to consider the challenges that clinical nurse educators encounter in practice, the location of nurse educators within the structure of nursing programs, and the effects of such positioning on the individual clinical nurse educator, the instruction, and the students and students’ learning. As I analyzed each situation, I began to uncover deeper problems.

I realized the importance of both these moments as they had prompted my enrolling in a doctoral program in education, in order to deepen my understanding of how to teach differently. In that program, I read about philosophies and ideas related to curricular development and teaching. I enjoyed the classroom experiences in which I observed how teachers taught, and particularly how their approach to teaching encouraged students to discuss issues; and I enjoyed the richness of subsequent dialogue and debate. The small group work where each student shared her/his ideas allowed each of them to deepen and challenge each other’s understandings. I pondered over the texts with ideas that resonated with my own experiences in nursing. I contrasted the teaching methods used in the doctoral program in education with my previous graduate program in nursing. During this phase, I found myself vacillating between the progressive and synthetical phases described by Pinar. I read more in-depth the work of certain education scholars such as John Dewey (1938/1997), Freire (1998), and bell hooks (1994, 2015). I realized how my previous experiences contributed significantly to my current research interests in nursing education. I then decided to examine teaching in the clinical arena, which led me to developing this research study.

As I continued my studies in curriculum, I began developing my personal philosophy of teaching and learning, which was informed by certain education scholars. Theoretical assumptions guide and inform one’s practice whether it be nursing or the teaching of nursing. A teacher’s theoretical assumptions are evidenced in her/his teaching practice as she/he adopts ideas or viewpoints that most likely align with her/his values and beliefs. For instance, I found ideas forwarded by Dewey (1938/1997) and Freire (1998) on teaching and learning resonated with my student experience and thus began to integrate them into my teaching practice. Dewey
(1938/1997) focuses on the interrelationship of the learner, the learner’s experience, and the influence of society on the learner (Ayers, 1988; Deng & Luke, 2008). Learning involves integrating the student’s perspectives, abilities, learning needs, and their experience of the issue. Dewey (1938/1997) viewed education as a process for improving the human condition and claimed that curriculum should address students’ quest for knowledge, the individual’s interests, and engage the student in problem solving. Dewey states (1938/1997):

[I]t is the educator’s responsibility to ensure that the problem grows out of conditions within the capacity of students; and secondly that it is such that it arouses in the learner an active quest for information and for production of new ideas…This process is a continuous spiral. (p. 79)

Thus, from this perspective, effective learning involves integrating the student’s prior learning experiences, learning needs, and abilities. By engaging a student in the learning process, the student’s whole being becomes engaged in the learning, and this can result in learning that “goes beyond” what the individual has been and creates a new meaning and understanding for the individual. Learning becomes part of the continuum of growth and empowers through processes of engagement, reflection, dialogue, and praxis (Allen, 2010; Tanner, 2007b).

I found unity in the ideas expressed by both Dewey and Freire, which led me to consider, adapt, and integrate the work of both authors in my teaching practice. Both Dewey and Freire propose a democratic understanding of education that “focuses on the facilitation of growth” for the individual (Shyman, 2011, p. 1035), although each author approaches the importance of democracy in education from a different perspective. Freire expands on Dewey’s ideas on experiential learning and suggests that educational praxis should combine both action and reflection as part of the educative process (Breunig, 2005; Freire, 1998).

I found that each author contributed significantly to my understanding of how students learn and how to facilitate learning. The course readings in my doctoral program enabled me to examine my teaching practice and reflect on teaching interventions and interactions with student nurses. However, in my education institution and in my teaching practice, I encountered a number of challenges to my ways of thinking and teaching. Thus, I began to read more widely and deeply in order to have a better understanding of the work of education scholars. I soon found that by adopting and adapting the work of certain education scholars into my teaching
practice, both in the classroom and clinical arena, I was able to better facilitate student learning and support students in their transition of becoming a nurse.

As I reflect on my teaching practice, I have found that student nurses need more guidance in understanding the significance of the content in order to learn to provide safe and effective care to patients. Also, I have realised that by modifying my lesson plans to meet the needs of learners and engaging students in dialogue that I am able to instruct more effectively in the clinical area.

Summary of Chapter

In this chapter I provided a broad understanding of the education preparation of nurse educators and focused specifically on the role of the clinical nurse educator. Also, I introduced some main elements of the undergraduate nursing curriculum and situated these ideas in the broader nursing education literature. I briefly introduced the influences from the education literature that influenced my teaching and will expand on these ideas in the next chapter.
Chapter 2.0 Grounding the Inquiry in the Literature

Overview of Chapter

In this chapter, I focus in more depth on specific ideas introduced in the previous chapter so as to further situate the study within a broader nursing and education context. This chapter consists of four main sub-sections that relate to the following issues. In the first section, I introduce important studies related to curriculum development and pedagogical practices of nurse educators; in the second section, I draw parallels between teacher educators and nurse educators in order to describe some similarities between the two groups. Also, I situate important elements that emerged from this study results in teacher education literature. In the third section, I introduce two approaches, a Tylerian and a constructivist approach to curricular development and pedagogy so as to frame and conceptualize some important results that emerged from the data; and, in the final section, I introduce and discuss the theoretical lens, a critical pedagogical lens that guided me in conducting this study. This lens enabled me to examine and explore in detail important issues that emerged from the data.

The purpose of this study is twofold: to examine the pedagogical practices of clinical nurse educators and to explore the challenges that they encountered while teaching in the clinical arena. A preliminary review of the literature in nursing education guided the formulation of the broad research and interview questions used in this study. I have used Charmaz’s grounded theory methodological approach in which she suggests that researchers conduct a preliminary review of relevant literature to obtain conceptual clarity of the problem under investigation (Charmaz, 1990; Chen & Boore, 2009; Corbin & Strauss, 2015; Denzin & Lincoln, 2011;).

2.1 Curricula and Pedagogy in Undergraduate Nursing Education

In this section, I delve more deeply into undergraduate nursing curricula and discuss relevant studies on teaching in nursing and clinical teaching so as to further situate this study in education literature in nursing.

Nursing curricula has relied on traditional pedagogy for over twenty-five years (Ironside, 2001, 2004), and nurse educators are “comfortable in conventional pedagogy (i.e., outcome-based or competency-based teaching) in which selecting, sequencing and transmitting content takes center stage” (Ironside, 2004, p. 6). Ironside (2004) adds that most nurse educators focus mainly on adding content and that “little or any content is taken out” (p. 6). In addition, it
appears that course material is added or swapped around with minimal consideration given to the actual learning experiences that student nurses encounter in their practice.

Tyler’s behaviourist model, a predominant teaching model found in the early 1930’s also known as conventional and/or traditional pedagogy, is commonly found in undergraduate nursing curriculum (Diekelmann, 1990, 2001; Diekelmann & Smythe, 2004; Diekelmann & Lampe, 2004; Ewashen & Lane, 2007; Giddens & Brady, 2007; Ironside, 2001, 2004, 2005a, 2015; McAllister, 2005a, 2005b; Mitchell, Jonas, & Cross, 2012; Stanley & Dougherty, 2010; Tanner, 2007a; Walker, 2005, 2009). I describe Tyler’s approach to curricular development and instruction later in this chapter under the heading “Grounding the Inquiry in Education Literature.”

Benner, Sutphen, Leonard, and Day (2010) conducted a study of nine nursing schools in the United States. The authors found that the traditional approach to curricula development and pedagogy in undergraduate nursing curriculum was pervasive. In their study, they selected one diploma, three traditional baccalaureate degree, two fast-track baccalaureate degree and master’s programs with an “excellent reputation for teaching and learning and a high state board examination pass rate” (p. 232). The researchers observed nurse educators’ teaching one introductory course and one advanced course that were pivotal to students’ learning. The purpose of the study, supported by the Carnegie Foundation for the Advancement of Teaching, was to determine “signature pedagogies of professional education; compare and contrast teaching methods…how to educate for competence and integrity and how to educate for professional judgement and teach complex skills” (p. 231). The data were collected from the direct classroom observation of nurse educators, the observation of students engaged in clinical practice, student interviews (individual and group interviews), faculty interviews (individual and group interviews), and the examination of course documents from participating nursing programs. One result revealed that nurse educators teaching in the classroom relied heavily on “slide presentations and standardized lectures…discussion was cursory and some faculty even limited questions, not wanting to be pulled too far from the slide presentation” (p. 13). The authors concluded that nurse educators should identify the assumptions that guide their teaching in order to address the quality of education in nursing programs.

2.1.1. Classroom Practice Divide
Benner and colleagues (2010) observed nurse educators while they were teaching in the classroom and the clinical arena. They noted a sharp contrast in pedagogical practices between classroom teachers and clinical nurse instructors:

Teachers in the classroom often rely heavily on automated presentation software and use pedagogical strategies that are significantly less effective than teachers generally use in the clinical setting and skills lab, where knowledge acquisition and use are more integrated. (p. 65)

On examining the above quotation more closely, it seems that classroom nurse educators tended to use a traditional pedagogical approach to instruction whereas clinical nurse educators tended to use a situated pedagogical approach linking knowledge and practice. On examining the assumptions that underpin a traditional approach to teaching and learning, two main suppositions appear. First, that students demonstrate their knowledge of content and thinking by rote memorization, recall, and applying knowledge to specific questions and/or situations. Second, the learning situation is entirely dependent on the teacher’s knowledge and expertise, and learning is entirely teacher-directed.

On examining the learning experiences of nursing students, Benner and colleagues (2010) found that

students do not fail to notice the sharp divide between the pedagogies of the classroom and the effective pedagogies of situated teaching in the clinical setting, and they find this divide perplexing not only because they learn so well in one arena and struggle to learn in the another, but because the classroom experience is at odds with the strong ethos that results in deep commitment to professional values (and….deep personal transformation). Classroom teachers must step out from behind the screen full of slides and engage students in clinic-like learning experiences that ask them to learn to use knowledge and practice thinking in changing situations, always for the good of the patient. (p. 14)

This excerpt uncovers a sharp contrast in the pedagogical practices between nurse educators teaching in the classroom and nurse educators teaching in the clinical arena and how this impacts learning. The authors found that student nurses tend to learn more deeply when nurse educators use a situated pedagogical approach compared to a traditional Tylerian approach used in the classroom. Clinical nurse educators appear to engage students in learning to think and make decisions within a complex and changing health care milieu, thereby facilitating the application of student learning to the nursing context. By contrast, nurse educators teaching in
the classroom tended to provide information in a static, linear manner that seemed to have minimal effect on student learning outside the classroom.

While this study provided a much needed general analysis of teaching practices in nursing, I found certain areas needed more examination, specifically a more detailed study of pedagogical practices of clinical nurse educators, their motivation and rationale. This issue is addressed more fully later in this thesis.

Benner and colleagues (2010) alluded to specific factors that appeared to widen the classroom-practice divide. The authors noted that most participants teaching in the classroom seemed to depend on the standardized packaged lectures to compensate for the lack of knowledge or currency of knowledge of nursing. One study participant stated that “none of the faculty teaching nursing theory or clinical courses were teaching clinical nursing and were out of step with current clinical practice” (p. 69). In this study, currency of nursing knowledge also emerged as an important issue and is discussed in the “Discussion” chapter of this thesis.

Also, Giddens and Brady’s (2007) study revealed that most nursing faculty seem to “have clinical or research expertise, as opposed to educational preparation, resulting in many faculty lacking teaching expertise” (p. 66). The lack of education preparation of nurse educators is a recurrent theme reported by many nurse researchers over the last twenty years (Boyd, 2010; Davidson & Rourke, 2012; Fanutti, 1993; Higgs & McAllister, 2007; Kramer, 1996; McDonald, 2004; Pauling, 2006; Ruby, 2000; Testut, 2013; Young, 1999). Nurse educators’ lack of formal preparation in teaching seems to constrain nursing faculty from critically selecting and integrating relevant content, developing curricula and using progressive pedagogical approaches in their teaching.

The classroom-practice divide is further exacerbated by existing policies within the academic unit and/or academic institution. Ruby (2000) conducted a qualitative study using grounded theory methodology, in which she interviewed fourteen nurse educators from six colleges and universities in New York, USA. The purpose of the study was twofold: to explore nurse educators’ perceptions of their professional obligations and to understand how they reconciled those obligations with external demands. One important theme that emerged was that academic units/institutions did not value or support nurse educators in their clinical teaching. Nurse educators who believed in maintaining clinical competency were overloaded with responsibility for teaching, research, and service. The participants stated that this constituted an
“invisible practice, translated into an unrewarded activity and (is) often not considered in promotion…or other institutional rewards” (p. 156). Participants reported not feeling understood or supported by their nursing colleagues and academic units/institutions, which resulted in feelings of dissatisfaction, burnout, and, in some cases, leaving the unit/institution. It seems that knowledge gained in the classroom is valued more than knowledge gained from clinical experience. Also, objective, measurable forms of knowledge seem to be privileged over experiential and reflective knowledge. In this study, participants portrayed and discussed varied forms of knowledge that they used in their teaching, and these are discussed in the “Results” and “Discussion” chapters of this thesis.

I examined studies specifically relating to nurse educators, clinical nurse educators and teaching in the clinical arena and found a limited number of studies. Scanlan (1996), one of the earliest researchers that specifically examined teaching in the clinical arena and the teaching practices of clinical nurse instructors. The purpose of this descriptive study was to explore the thinking of novice and expert clinical nurse instructors in Manitoba, Canada. Ten participants from four diploma programs and one baccalaureate nursing program participated in the study. A purposive sampling of ten participants, five novices, and five expert clinical instructors was used. The investigator used semi-structured interviews to collect data. Three major themes emerged from the data: learning clinical teaching; practices of clinical teachers; and knowing students. The first theme, learning clinical teaching, explains how both groups of clinical instructors, novice and expert, learned to teach. The second theme describes the practices of clinical teachers and focused on the specific instructional activities of participants such as questioning, answering queries, monitoring, developing and evaluating assignments. The third theme, knowing students, focused on students’ knowledge of nursing.

In order to gain a deeper understanding of the issues than the design Scanlan’s (1996) study allowed, I explore in greater detail participants’ thinking about their actions and their decision-making process. Also, I find certain assumptions made by Scanlan to be problematic. For instance, Scanlan used a simplistic identification of clinical instructors as novice or expert through the single criterion of years of teaching experience as the measure that differentiated these groups. Novice educators were defined as teaching less than two years whereas expert nurse educators were defined as those who taught for more than seven years. However, I found that the nursing education preparation of the novices was actually higher than that of the expert
group. As I will show later in this thesis, teaching experience alone does not fully describe the
development of teaching knowledge and expertise and that knowledge of teaching gained in a
systematic manner does enhance the teaching practice of nurse educators.

Also in this study, I focus not only on participants’ teaching activities in the clinical arena
but also on the ways that they contributed to student learning. This is an important contribution
as the work of clinical nurse educators remains invisible in the nursing education literature. In
addition, the results from this study reveal problems related to curricular development and the
culture of teaching in undergraduate nursing programs-two topics that have not been previously
examined in this body of literature.

2.2 Parallels between Teacher Educators and Nurse Educators

In this section, I draw parallels between teacher educators and nurse educators in order to
highlight a few similarities between the two groups which has enabled me to situate the
education preparation of nurse educators more deeply in the literature. Furthermore, I draw on
teacher education literature to describe and explain certain concepts that emerged from the data
such as, the concept of pedagogical content knowledge (Fenstermacher, 1994; Shulman, 1987)
that teachers use in their practice. This concept is absent in the literature in nursing education but
described in-depth in teacher education literature. This concept provides an important conceptual
means for understanding the teaching practice of participants because it links the knowledge of
content in nursing to considerations of how that particular content might best be taught in order
for learning to occur. Also, the teacher education literature has rich, substantive research on
developing curricula and in using progressive pedagogical approaches that I draw upon in the
“Discussion” and “Recommendations” chapters.

Unlike school teachers, teacher educators engage in teaching about teaching, and it is this
double-layered focus on teaching that makes the work of teacher educators unique (Loughran,
2011; McKeon & Harrison, 2010; Murray, 2005).

There are, as I describe here, six common similarities between teacher educators and
nurse educators. First, teacher educators like nurse educators learn to teach on the job (Acker,
1997; Dinkelman, Margolis, & Sikkenga, 2006; Fanutti, 1993; Murray, 2005). I suggest that one
reason nurse educators have not received education preparation in teaching could be traced to
policy changes in 1969, which I described in the “Introduction” of this thesis. Also, it seems that
currently the nursing profession is unaware of or does not recognize the knowledge, experience,
and expertise required to teach nursing. I argue that the practical knowledge of teaching acquired in the workplace needs to be developed in a systematic, reflective manner in order for the individual nurse educator to gain competence and confidence in her/his teaching (Murray, 2005). Additionally, the results from this study reveal that participants with formal education in teaching were able to assess and provide pedagogical interventions in a more explicit and timely manner.

A second similarity is that teacher educators have a wealth of knowledge and expertise in school teaching and this is often the main reason for their recruitment to institutions of higher education (Murray, 2005). Similarly, nurse educators in general and clinical nurse educators in particular are typically hired for their knowledge of nursing practice and clinical content and most have minimal knowledge of pedagogy (Boyd, 2010; Davidson & Rourke, 2012; Guy, Taylor, Roden, Blundell, & Tolhurst, 2011; Higgs & Mcallister, 2007). In addition, most nurse educators learn to teach on the job and teach the way they were taught (Ruby, 2000; Scanlan, 1996; Young, 1999).

Third, new teacher educators rely heavily on their previous teaching and schooling experiences to make decisions (Dinkelman et al., 2006; MacNeil, 1997; McKeon & Harrison, 2010). However, transferring skills from school teaching to teaching in institutions of higher education is not always a straightforward process as the skills learned may not meet the learning needs of students in higher education institutions. As school teachers develop into teacher educators, they learn to integrate their learning from a variety of sources: experiences, reflections, conversations with colleagues, and integration of concepts of teacher education in their practice. Similarly, most nurse educators rely on their nursing knowledge and experiences when making decisions related to students and how students learn, teaching in ways that are grounded in the practice of nursing and not the teaching of nursing (Diekelmann, 2004; Ferguson, 2005). I argue that using a nursing approach in one’s teaching practice is problematic as students’ learning needs are quite different from knowing how to care for a person. Also, the results from this study further reveal that participants needed to discern the different needs and vulnerabilities between patients and student nurses in their teaching practice. As I illustrate later in this thesis, participants needed to learn how to negotiate between patients and students in making their decisions. Also, the results reveal that using nursing knowledge to develop nursing curricula is problematic and this result is described in the “Discussion” chapter.
Fourth, both teacher educators and nurse educators experience tension between supporting students and developing their scholarship of teaching and research (Acker, 1997; Boyd & Lawley, 2009; Loughran, 2011; McArthur-Rouse, 2008; Murray, 2005), and both groups may focus more on their teaching assignments than on supporting students. Most nurse educators struggle with establishing their research portfolio as they juggle their teaching and professional responsibilities. Furthermore, in institutions of higher education whose reputation rests on research and publication, research remains a priority and teaching is seen as less valuable (Dinkelman et al., 2006; Prior, 1965). Also, most nurse educators receive little or no support from nursing and/or education departments in developing their research portfolio.

Fifth, teacher educators feel that a decrease in their interaction with students in schools would compromise their ability to relate to student teachers and/or provide insights and practical solutions to issues raised in practice (Boyd & Harris, 2010; Dinkelman et al., 2006). Similarly, nurse educators worry about loss of professional credibility as they transition from practice institutions to post-secondary educational institutions. In addition, clinical nurse educators in particular state the importance of remaining current about nursing practice and health care issues (Boyd, 2010; MacNeil, 1997; Smith & Boyd, 2012) in order to provide contemporary information to students.

Last but not least, teacher educators and nurse educators report feeling stressed and anxious as they transition into academic institutions, describing feelings of isolation and alienation. The cause of stress are related to factors such as adjusting to the new role, difficulty in adjusting to teaching adults in the academic settings, and to uncertainty about expectations of teaching in institutions of higher education (Acker, 1997; Boyd & Lawley, 2009; Boyd & Harris, 2010; Gardner, 2014; McArthur-Rouse, 2008; Murray, 2005; Murray & Male, 2005; Wilson, 2010). Also, both groups report feeling disempowered due to their lack of knowledge of the new environment (Diekelmann, 2004; Murray & Male, 2005).

2.2.1. Distinctions between Teacher Educators and Nurse Educators

One important difference between teacher educators and nurse educators is found in their teaching focus. Both roles place a great deal of responsibility on the individual, but teacher educators are concerned with preparing teachers to teach in primary, secondary, and post-secondary classes, while clinical nurse educators are concerned with teaching students to become competent nurses—a role that has significant consequences and a very particular set of
responsibilities. Also, curricular content and professional licensing requirements influence the pedagogical practices of nurse educators differently than those of teacher educators.

2.2.2. Important Differences between Classroom and Clinical Nurse Educators

From my observations and anecdotal accounts of others in the field, it seems that three important differences characterize the roles of nurse educators teaching in the classroom and nurse educators teaching in the clinical arena.

2.2.2.1. Education preparation

The first difference appears in the educational preparation of nurse educators. It seems nurse educators teaching in the classroom generally possess a doctorate in nursing, whereas most clinical nurse educators generally possess a master’s degree in nursing. In undergraduate nursing programs in Toronto, Canada, a PhD is the required credential in order to teach at the university level and is preferred at the college level.

However, results from a study conducted by Young (1999) reveal that obtaining a doctorate in nursing does not actually prepare nurse educators to teach. Also, in most cases, doctorally prepared nurse educators are entrusted to develop and design curricula. I argue that, although doctorally prepared nurse educators have expertise in a particular area in nursing this does not prepare them with theoretical knowledge to develop curricula or effectively design an education program. Furthermore, the results from this study indicate that formal preparation in education does enable nurse educators to teach in a more effective manner.

2.2.2.2. Employment status

The second difference lies in their employment status. Nurse educators teaching in the classroom are hired on a permanent basis, whereas clinical nurse educators are more likely to be hired on a contractual, sessional basis. Also, it seems that clinical nurse educators receive minimal orientation to their role where employment issues, course objectives, and evaluation methods are discussed simultaneously. In some cases, clinical nurse educators are hired only a week or a few days before the start of the semester and, in most nursing programs, orientation for clinical instructors is not standardized (Davidson & Rourke, 2012).

I suggest that the casualization of the clinical nurse educators’ role and the lack of adequate orientation for the role have a negative impact on the clinical nurse educators’ sense of their own value in the profession and that these various practices ultimately affect teaching in the clinical arena. For example, researchers (Lofmark, Carlson, & Wikblad, 2001; Lofmark &
Wikblad, 2001; Ralph, Walker, & Wimmer, 2009) studying student nurses and the effectiveness of clinical instruction reported that student nurses noted the importance of having consistent and good supervision in order for learning to occur in the clinical arena, qualities that are not supported by the differences in the context described above.

2.2.2.3. Roles and responsibilities

A third and important difference between classroom and clinical nurse educators lies in how their roles and responsibilities are defined. A clinical nurse educator teaches students within a health care milieu and must be aware of multiple needs: those of the patients, of the students, of the education institution and of the nursing unit. A clinical nurse educator assumes a number of interrelated roles such as a nurse clinician, teacher, mentor, counsellor, and mediator, simultaneously (Adams, 2010; Kopala, 1994; Stokes, 2007). For instance, when teaching student nurses about nasogastric tube insertion in the clinical arena, the clinical instructor needs to be both a competent practitioner in performing that skill and be prepared to deal with potential complications. Clinical nurse educators need to be aware of the learning opportunity that each clinical situation offers the student; the learning needs and abilities of each student in the group; the impact of the procedure on the patient and the assigned nurse’s role—altogether a complex task to be carried out within a limited time frame. The primary responsibility for the clinical nurse educator is ensuring that student nurses learn to provide safe and competent care to patients. Clinical nurse educators have dual responsibilities to students and patients, and are operating with limited resources. By contrast, in a classroom, the primary focus of a nurse educator is on teaching students.

In this study, I examine how participants made decisions, the factors that influenced their decisions, and how they negotiated between their teaching and nursing practice. Also, I delve more deeply into the teaching experiences of clinical nurse educator participants in order to shed light on the complexity involved in teaching in the clinical arena and the factors that influence and/or impede their clinical teaching practices. This is an important yet missing element in nursing education literature.

2.3 Grounding the Inquiry in Education Literature

In this section, I first introduce a few important concepts from education literature in order to position this study within a broader education context. First, I introduce and explain important concepts such as curriculum, andragogy, and pedagogy used in this study and describe
important features of each. I then delve more deeply into a Tylerian view of curricular development and pedagogy so as to situate the results within a broader curricula context. Also, I introduce broad features of constructivism so as to conceptualize the teaching approach of participants that emerged from the data.

2.3.1. Curriculum, Andragogy, and Pedagogy

The term curriculum has evolved over time, and its changing meanings can be understood as lying along a continuum. In its earliest conception, curriculum was understood very concretely as an outline of a course of study and the organization of plans and programs that students were expected to learn (Deng & Luke, 2008; Klein, 2001; Macdonald, 1971; Tyler, 1969). Other conceptualizations focused specifically on the experiences of students in school (Casey, 1996; Dewey, 1938/1997; Emes & Cleveland, 2003). Later, the focus shifted from this more externally based definition to a more internal, subjective, and reflective process that is similar to an autobiographical journey (Pinar, 1975). Conceptually, curriculum now is understood more contextually to include everything that occurs in the “course of planning, teaching, and learning in an educational institution” (Giroux, Penna, & Pinar, 1981, p. 17).

Pinar (2004, 2012) explains the term curriculum as currere—a journey undertaken by teachers and students in understanding the meaning of the educational experience. I find Pinar’s explanation a useful and evocative image that describes the practice of teachers broadly. The term includes both temporal and cognitive elements. Currere attempts to make visible the relationship between the knower and the known, the learners and their knowledge. Nurse educators’ understanding of this concept has also evolved over time. As I will show in the “Discussion” chapter in this thesis, differences emerged between participants’ understanding of currere and nurse educators teaching in the classroom that emerged from the data.

2.3.1.1. Andragogy

I first explain andragogy, provide a brief overview of its main features, and then provide my rationale for using the concept of pedagogy rather than andragogy in this study.

Knowles defined andragogy as “the art and science of helping adults learn” (Knowles as cited in Davenport & Davenport, 1985, p. 152). Although this term was originally coined in 1833 by Kapp, a German teacher, Knowles is credited with reintroducing and developing it as a concept. In addition, Knowles developed the concept of andragogy to give coherence and
direction to the educational preparation of adults. Knowles proposed four assumptions that differentiated adult learning from childhood learning:

As a person matures, the self-concept moves from dependency towards self-direction; maturity brings an accumulating reservoir of experience that becomes an increasing source for learning; as the person matures, readiness to learn is increasingly oriented towards the person’s social roles; and as the person matures, the orientation towards learning becomes less subject-centered and increasingly problem-centered. (Knowles as cited in Davenport & Davenport, 1985, p. 152)

Education scholars such as Elias (1979) and Hartree (1984) critiqued some of Knowles’ assumptions. Both authors suggest that Dewey built a theory of education based on the child’s experience and stressed the importance of problem-centred learning and autonomy for all learners, therefore the child/adult distinction that Knowles made seems unwarranted.

Knowles, in later revisions to the concept of andragogy, suggested that “andragogy was more of a technique than a theory” (as cited in Davenport & Davenport, 1985, p. 155); while Hartree (1984) suggests that andragogy is but one method of instruction among many methods of teaching.

I also find certain assumptions suggested by Knowles problematic. For instance, Knowles suggests that andragogy “assumes that the point at which an individual achieves a self-concept of essential self-direction is the point at which he psychologically becomes an adult” (Knowles as cited in Hartree, 1984, p. 205). Most students enroll in undergraduate programs at around seventeen to eighteen years of age and from my observation of student nurses over the years, I have seen a lot of variation in the concept of self-direction among student nurses as they progress through their undergraduate nursing program. Some students are able to identify and meet their learning goals regardless of their age and thus it seems that an individual’s conception of self-direction is influenced by a number of factors rather than something that can be represented by a specific age related criterion. It seems the differences between child and adult learners that Knowles described relates more to context and situation. Also, differences in the learning needs of adults or the different situational constraints that adult learners encounter were not really addressed by Knowles. Instead, the concept of pedagogy with its progressive approach to teaching, regardless of the age of the learner, can better inform the main research questions in this study. For these reasons I am using the concept of pedagogy.

2.3.1.2. Pedagogy
Historically, pedagogy has been described as the teaching of children (Harden, 1996; Pew, 2007). However, the validity and value of this distinction continues to be debated and the assumptions about how to teach children has changed radically from when this term was first introduced. Currently, pedagogy is defined more comprehensively and not only by age.

Some education theorists define pedagogy as the art and science of teaching, while others focus on the relationships between learning and teaching as interdependent elements (McKeon & Harrison, 2010). Others define pedagogy as the relationship between the nature of knowledge, what and how it is taught, and learning (Diekelmann, 2001; Horsfall, Cleary, & Hunt, 2012; Ironside, 2001, 2015; Mitchell, Jonas, & Cross, 2012). Pedagogy is also understood as the transformation of consciousness that takes place at the intersection of three agencies—the teacher, the learner, and the knowledge that they produce together (Harden, 1996). Pedagogy is understood as both the visible and the hidden interactions between student and teacher that is oriented towards learning (Shudak, 2014). With the current understanding of learning as a constructive process, the way teaching is understood and implemented has changed. As learners’ considerations became central, how something is taught becomes the mediating process between the learner and the subject matter’s content. For these reasons I have used this concept to describe the pedagogical practices of participants.

Pedagogy is understood as a process that begins “with an act of reason, continues with the process of reasoning and culminates in performance of imparting, eliciting, involving…until the process can begin again” (Shulman, 1987, p. 13). Pedagogical reasoning is embedded in the teaching process. In this study, the pedagogical reasoning of participants is found in their actions and decisions and is discussed in the “Results” chapter of this thesis. Also, I explicate the pedagogical reasoning of participants as it is an important but missing element in nursing education literature.

Pedagogical reasoning includes comprehension, knowledge transformation, instruction, evaluation, reflection, and new comprehension. The elements are interchangeable and used by teachers to meet the learning needs of students. A teacher could use certain aspects of the approach more frequently, in more pronounced ways, and in a different order. Comprehension is where the teacher understands critically the set of ideas that should be taught; how a given idea relates to other ideas within the same subject and/or to ideas in other subjects (Shulman, 1987). It includes the teacher’s ability to transform the content knowledge that she/he possesses into forms
of knowledge that adapts to varied student audiences. Transforming content knowledge includes
a number of processes such as the critical interpretation of the texts, representation of the ideas in
the form of new analogies, choosing appropriate instructional methods, and adapting to the
particular learning needs of students in a specific classroom. In addition, a teacher’s values and
beliefs guide the individual during this process. Instruction includes the observable performance
of a variety of teaching actions such as organizing and managing students, interacting effectively
with students through questions and probes. Evaluation includes checking for understanding or
misunderstanding and providing formative and summative feedback.

Pedagogical reasoning includes critical thinking and is defined as the “skillful,
responsible thinking that facilitates good judgment” (Henze, 2009, p. 96). Critical thinking
consists of three important features: criteria, self-correcting, and sensitivity to context.
Pedagogical reasoning then, is a complex intellectual process that competent teachers engage in
on a regular basis. This form of reasoning is absent in the nursing education literature but is
described in detail in the literature in teacher education, and so again I have drawn on this
teacher education literature to explain this concept more fully.

2.3.2. Approaches to Developing Curricula

In this section, I provide a broad overview of two approaches to developing curricula as
described in teacher education literature in order to explicate some important ideas that emerged
from the data. First, I provide an overview of some of the main assumptions found in a
traditional Tylerian approach followed by a broad overview of a constructivist approach to
education. As mentioned in the “Introduction” chapter, nursing curricula has mainly adopted a
behavioural approach to education (Ironside, 2001, 2003, 2004) and one such approach could be
found in the work of Ralph Tyler, a prominent education scholar that influenced education in the
late 1940s. Tyler’s approach to education has characterized, and continues to characterize most
undergraduate nursing education pedagogy (Diekelmann & Smythe, 2004). In this section, I
introduce some main features of this approach and in the “Discussion” chapter I explain in detail
the problems related to using this approach in educating student nurses in the current health care
environment.

In 1949, Tyler developed an education approach to guide school administrators in
developing curricula. Tyler’s approach to education was influenced by changes in society,
particularly the occurrence of two world wars and the rapid acceleration of information. Tyler’s
theory focused primarily on efficiency, control, prediction, and on training students to meet predetermined outcomes within specific time frames (Richardson, 1996). His approach epitomized “the traditional scope of curriculum and encountered widespread acceptance” as it attempted to guide and control learning (Giroux et al., 1981, p. 4).

On examining the assumptions that underpin Tyler’s approach to curricula development, knowledge, and instruction, I found areas of concern for the education of student nurses in undergraduate nursing programs, highlighted in the following sections.

2.3.2.1. Development of undergraduate nursing curricula using Tyler’s approach.

Tyler (1949) suggested that educators focus on the following four questions in building a curriculum:

- The selection and definition of the learning objectives,
- The selection and creation of appropriate learning experiences,
- The organization of the learning experiences to achieve a maximum cumulative effect,
- The evaluation of the curriculum to furnish a continuing basis for necessary revisions and desirable improvements. (Tyler as cited in Giroux et al., 1981, p. 23)

In using a traditional approach to curriculum, teachers focus on identifying and selecting appropriate learning objectives and evaluation methods. This approach stresses “mission specificity [and] time on task variables” (Giroux as cited in Giroux et al., 1981, p. 101). Students’ learning needs, their understanding and/or interpretation of content are not deemed relevant, and their ability to construct their knowledge is minimized, ignored, and/or dismissed. Also, the variability amongst learners and diversity found in the teaching and learning context is not considered in the design of instructional activities.

Benner and colleagues (2010) found the traditional approach to curricular development in nursing problematic because the focus was solely on content rather than on student nurses’ understanding of information, or whether students were integrating their knowledge from their course work in their clinical practice and vice versa. These researchers also found that nurse educators worked in teams to develop course curricula and objectives and that not all nurse educators in the team agreed on the content or how to approach the content. However, the content remained static and a lecture approach was commonly used. One of the study participants noted, “We have this idea that these words were said in class, therefore the students have learned the content. Well no, they haven’t” (Benner et al., 2010, p. 71). This comment
raises two important concerns. First, nurse educators seemed preoccupied in delivering content and unaware of how this information was understood by the learners. This comment also illustrates how participants raised questions about the course objectives, yet their concerns about the content and the variability among the learning needs of the learners were ignored. The focus, it seems remained on creating and prescribing a uniform list of objectives rather than on creating the conditions for effective student learning by understanding students’ prior knowledge, nursing experiences and linking how that content is presented to students’ current state of understanding.

2.3.2.2. Knowledge claims using Tyler’s approach.

In a Tylerian approach, the main purpose and function of knowledge is assumed to be that which allows the learner to complete tasks in an efficient manner (Giroux et al., 1981). A teacher’s main focus is thus to carefully pre-select objectives and to sequence learning experiences in order for learning to occur. Giroux states that knowledge claims using a Tylerian approach is understood as follows:

Knowledge is treated primarily as a realm of objective facts external to the individual and is imposed on him or her. As something external, knowledge is divorced from human meaning and intersubjective exchange. It is no longer seen as something to be questioned, analyzed and negotiated. It becomes something to be managed and mastered. In this case, knowledge is removed from the self-formative process of generating one’s own set of meanings, a process that involves an interpretive relationship between the knower and the known. Once the subjective dimension of knowing is lost, the purpose of knowledge becomes one of accumulation and categorization. Questions such as “why this knowledge” are superseded by technical questions such as what is the best way to learn this given body of knowledge. (Giroux as cited in Giroux et al., 1981, p. 101)

In a Tylerian approach to education, the teacher’s knowledge and the prescribed meanings assigned to given texts by the teacher are considered the only valid form of knowledge. Alternative meanings and interpretations are ignored or minimized, and the influences that surround understanding and/or meaning are also typically ignored. Dialogue and debate are discouraged and considered unnecessary in such a teacher-centered approach. The student is considered a “tabula rasa,” an empty vessel devoid of knowledge or experience, waiting to be filled with knowledge that the teacher has deemed important. In Tyler’s approach to teaching, knowledge is deemed hierarchical in nature with the teacher as the expert and holder of all valid knowledge (Kivunja, 2014).
2.3.2.3. Instruction using Tyler’s approach.

In a Tylerian approach to pedagogy, instruction is centered on the expert knowledge of the teacher and thus lends itself to a transmission form of instruction. Learners’ contribution to the learning process or their interpretation of content is not acknowledged except as evidence of gaining knowledge or lacking specific pieces of knowledge. Efficiency and expediency of providing large amounts of information in a sequential manner remains the focus, and lecturing is the predominant form of teaching. In most undergraduate nursing programs, lecturing enables nurse educators to convey large amounts of information to students within a short time frame (Young & Diekelmann, 2002). By treating the learning process as a homogenous entity, variability among the learning needs of student nurses is not acknowledged or addressed. The results from this thesis study clearly reveal the negative impact of a Tylerian approach to curricula development and pedagogy on learning, on student nurses’ ability to provide safe patient care, and on the teaching practices of clinical nurse educators. The results also reveal that by using more progressive approaches to instruction participants were able to build on students’ knowledge and understanding of content and guide them more effectively in their nursing practice.

2.3.3. A Constructivist Approach to Education.

I introduce a constructivist approach to learning and teaching in order to frame and conceptualize the teaching approach of nurse educator participants in this study. As I show later in the “Discussion” chapter that by using a constructivist lens I am able to highlight and contrast participants’ approaches to teaching with that of nurse educators teaching in the classroom.

Constructivism is a theory about learning and knowledge (Daniels, Lauder, & Porter. 2009; Ertmer & Newby, 2013; Fosnot, 2005; Fox 2001; Garrison, 1995; Henze, 2009; Jenkins, 2000; Phillips, 1995; Richardson, 1996, 2003) with implications for teaching (Brown 2006). Brooks and Brooks (2001) define constructivism as a way of knowing one’s world and state that there is a clear connection between “constructivism as an epistemological and philosophical image and constructivism as an educational framework” (p. 23). In essence, how educators come to know and understand the learning process influences their teaching practice. Constructivism offers a theory of learning that challenges some of the assumptions espoused by the dominant behavioural and cognitive views of learning (Fosnot, 2005; Fox 2001; Richardson, 1996).
Although the assumptions that underpin constructivism and cognitivism conceive learning broadly as mental activity, each offers a different view of learning and the construction of knowledge. Constructivism proposes that learning occurs when individuals filter input from their external environment, reflect on their experiences from their particular viewpoint, and construct a new understanding and meaning of the context. Learners construct knowledge by integrating the multiple influences that guide their learning. Teachers adopting a constructivist stance utilize certain forms of inquiry and classroom activities in order to enable learners to construct meaning of their experiences thereby building their knowledge of content and context. Cognitivism on the other hand, focuses mainly on the mental activities of individuals (Jenkins, 2000; Phillips, 1995) and cognitive theories focus on how information is “received, organized, stored and retrieved by the mind” (Ertmer & Newby, 2013, p. 51), and that knowledge acquisition depends on internal measures such as internal coding and structuring of information specific to each learner.

Constructivism consists of varied approaches and epistemological positions (Fox, 2001; Garrison, 1995; Henze, 2009; Jenkins, 2000; Phillips. 1995; Richardson, 1996) and proponents of constructivism come from diverse domains such as psychological, sociological and historical directions and support many versions of constructivism. Although constructivism supports diverse viewpoints, constructivists’ subscribe to important and overarching principles that are described below. In this study, I have used a social constructivist stance as it enabled me to best explain the results and describe some important features of this approach in a later section of this chapter.

2.3.3.1. Broad overview of constructivist theory.

The ideas forwarded in a constructivist approach are in sharp contrast to the ideas found in a behavioural approach advanced by Tyler (1969) in relation to knowledge claims and its implications for instruction. The differences in each approach influences how teachers understand learners, influences their philosophy of teaching and how they actually teach. The main assumptions that underpin constructivism are as follows:

1. Learners are viewed as “makers of meaning whose background understanding strongly affects the way in which they process and make sense of new knowledge” (Richardson, 1996, p. 263). Students engage and build upon their particular existing knowledge in constructing new understanding, new meaning, and new knowledge (Bächtold, 2013; Brooks & Brooks, 2001; Daniels et.al, 2009; Driver & Oldham, 1986; Driver, Asoko, Leach, Mortimer & Scott. 1994;

2. Learning is understood as an active process and learners develop knowledge through the integration of many forms of information and experiences. All learning such as, acquiring new skills or generating an explanation and/or evaluating ideas “requires re-interpreting the information to be learned or used in light of one’s existing understanding and abilities” (Daniels et.al., 2009; p. 31). Learning is understood as a process of making sense of one’s world and where knowledge is understood as constructed and emergent rather than fixed and discovered; and where Truth is understood as provisional rather than certain. Learning is viewed as a self-regulatory process where learners struggle between their existing understanding of the world and their new insights, and in the process create new representations and meanings within negotiated social structures (Driver & Oldham, 1986; Henze, 2009; Richardson, 1996, 2003).

3. Learning occurs through individual and social connections and knowledge is understood as being created by learners linking their experiences in the situation with content and in dialogue with others. Learning consists of the integration of theoretical concepts, practice, and context. Constructivism emphasizes the “flexible use of pre-existing knowledge rather than recalling pre-existing schema” (Ertmer & Newby, 2013, p. 56).

Construction of meaning is understood as an active and dynamic process where the learner generates tentative meanings and checks those meanings for coherence in a given situation. Checking involves using current knowledge of the situation, modifying and/or adapting prior knowledge or experiences of similar situations (Driver & Oldham, 1986). Construction of knowledge could be described in terms of individual cognition or in terms of social and political process or a combination of both (Phillips, 1995).

Similarly, learners construct their knowledge of science and scientific ways of knowing in the classroom and from their learning experiences. Driver, Asoko. et.al. (1994) suggests that scientific knowledge is “both symbolic in nature and also socially negotiated” (p. 5) and that scientific constructs have been “invented and imposed on phenomenon in attempts to interpret and explain them, … as a result of considerable intellectual struggles”(p. 6). Furthermore, scientific knowledge is understood as public knowledge that is constructed and communicated through the cultural and social institutions of science (Driver, Asoko et.al. 1994; Driver & Oldham, 1986). Although scientific knowledge has an empirical basis that requires validation,
this form of knowledge is socially constructed which has important implications for nurse educators and education in nursing. Instruction in the science of nursing involves being introduced to ideas and practices in a particular way and the role of an educator using this constructivist lens is to mediate scientific knowledge for learners, guide learners in making sense of the ways that knowledge claims are generated and validated and to re-construct, clarify their ideas through discourse (Driver, Asoko et.al. 1994; Driver & Oldham, 1986). For example, a nurse educator guides students in their understanding of analysing arterial blood gases and a clinical nurse instructor enables, guides students in applying that knowledge to analysing the blood gas results of their patients. Learners create their knowledge by making connections between and amongst various scientific constructs. Furthermore, students are introduced to particular ways of knowing within a discipline by more skilled members of that community. A more experience member such as a nurse educator supports the student nurse by structuring the learning process and enabling the learner to understand concepts, perform tasks and internalize the process. The challenge for the educator lies in guiding learners to appropriate these models for her/himself and to use and apply this knowledge appropriately within the particular domain (Driver, Asoko et.al.1994; Driver & Oldham, 1986).

Constructivism informs many current approaches to teaching, such as problem-based learning and student-centred approaches. An educator’s knowledge and understanding of constructivism influences their approach to pedagogy and student learning and the activities planned by a teacher that promotes thought, interaction and reflection on part of the learner showcase a teacher’s particular approach to pedagogy. A teacher using a constructivist approach engages students in their learning through careful selection of content and implementation of teaching strategies, and while some of these strategies could be described as formal and didactic other strategies could be described as exploratory in nature and these strategies are considered central to a teacher’s professional competence. In this study, the data revealed two groups of nurse educators based on their understanding of pedagogy; nurse educators teaching in the classroom and clinical nurse educators. Clinical nurse educator participants’ understanding of students’ knowledge differed significantly from nurse educators teaching in the classroom and is discussed in more depth in the “Discussion” chapter.

2.3.3.1.1. Social constructivism.
In this thesis, I utilize a social constructivist approach to explore and explain participants’ understanding of learning and teaching. As the name implies, this approach emphasizes the centrality of social aspects of the teaching and learning experience, and it enabled me to examine important factors that influenced participants in their teaching.

2.3.3.1.1. Knowledge claims found in a social constructivist approach.

In a social constructivist approach, knowledge creation is seen as contextualized within existing power, social, and political structures (Richardson, 1996, 2003). Social constructivism focuses “on the ways in which power, the economy, political and social factors affect the ways in which groups of people form understandings and formal knowledge about their world” (Richardson, 2003, p. 1624). This approach focuses on the effect of power, the political-social context on the individual’s understanding and knowledge formation about her/his world. I recognize that there are many strands within social constructivism (Henze, 2009); however, the predominant assumptions’ underpinning this approach provides the best fit to examine and explain the challenges that participants encountered.

2.3.3.2. A Social Constructivist Approach to Pedagogy.

While constructivism is a theory of learning, it has important implications for how teachers can facilitate learning. In constructivist pedagogy, learning is understood as “an active process of communicating, discovering, organizing and conceptualizing” (Henze, 2009, p. 99) and involves the creation of a classroom environment in which students are encouraged to interpret and voice their understanding in order to develop a deeper understanding of the subject matter. Creation of meaning is understood as a dialogic process that involves individuals in conversation with teachers, peers and others and is considered as important aspect of classroom discussion. The role of the teacher is that of a knowledgeable guide, where the teacher demonstrates a disciplinary approach to understanding and analyses of the subject matter; and guides students in examining alternate points of view. The teacher mediates ideas, engages students in co-constructing meaning and knowledge, and encourages them to act upon them. Important features of constructivist pedagogy (Fosnot, 2005; Richardson, 2003) include the following:

1. The teacher pays attention to the individual and respects the student’s background.
2. Dialogue is an important feature in this approach, with the purpose of developing a shared understanding of and beliefs about the topic.
3. Students are provided opportunities to add, determine, change, or challenge existing beliefs and understandings through engagement in activities structured for this purpose (Richardson, 2003).

4. Although direct instruction of formal domain knowledge occurs, students are encouraged to become more aware of how they learn and come to understand the world.

Constructivism does not preclude teachers from engaging in direct instruction. However, the amount of content, the amount of time spent in direct instruction, and the manner of instruction are all carefully considered and used flexibly according to the particular learning needs of the students. The teacher in preparing a lecture presentation is encouraged to focus on student understanding of the content instead of merely focusing on delivering large quantity of information. Also, a teacher needs to possess a good knowledge of the discipline, the practice context and pedagogy in order to develop learning activities that enable students to explore concepts, support dialogue, guide discussions towards a shared understanding, as well as correct misconceptions.

Using this approach to learn the science that underpins a discipline involves both, the individual and the social processes which include introducing the learner to concepts, symbols and conventions of the scientific community and into the particular discourse of that community (Driver, Asoko et al. 1994; Driver & Oldham, 1986). As I show later in this thesis, the participants engaged their students in a variety of active learning experiences while presenting theoretical nursing content. A social perspective on learning suggests that learners are introduced to scientific concepts through discourse and in the context of relevant tasks. The process of developing new ways of explaining usually involves a dialogic interaction between teachers and students or amongst learners. In these interactions, the teacher scaffolds concepts for the learner in order that the learner constructs new meanings for themselves. The teacher transforms content in order to develop new ways of explaining the content to the learner and in doing so guides learners in their re-construction of ideas through discourse. The teacher engages in activities that guide the learner in developing their meaning of the concept for themselves.

2.4. Theoretical Lens Used in the Study

In the above section, I introduced and described a social constructivist approach to teaching to illustrate the contrast between the teaching practice of study participants and those of nurse educators teaching in the classroom who continue to largely use a traditional approach to
teaching. In this section, I introduce a critical pedagogical approach which I have found helpful to explain the teaching practice of participants and in examining the challenges that participants encountered in their teaching practice. At the end of this section, I describe some of Freire’s (1998) ideas on critical pedagogy that I have used in this study as a way to frame some of the findings that emerged. I describe some key features of a critical pedagogy here and elaborate on these ideas in the “Results” and “Discussion” chapters of this thesis.

Critical pedagogy builds upon assumptions underpinning a social constructivist perspective, and educators adopting a critical pedagogical approach maintain that embedded in curriculum and schooling practices are processes that tend to perpetuate existing power structures and not recognize or acknowledge that such aspects of the “hidden curriculum” can actually impact the efficacy of teaching and learning. Educators that adopt a critical pedagogical stance reject the assumptions that underpin traditional pedagogy, which, as I have shown, is pervasive in nursing education (Diekelmann, 1990, 2001; Diekelmann & Smythe, 2004; Ironside, 2001, 2004, 2005a, 2015) with its focus on mechanical, standardized curriculum and prescribed way of teaching. Furthermore, Harden (1996) adds that “nursing education has submerged students in a situation in which critical awareness and response are practically impossible” (p.32).

2.4.1. Critical Pedagogy.

Critical pedagogy encompasses a variety of theoretical stances and continues to evolve over time (Giroux, 2004, 2007; Jackson, 1997; Kincheloe, 2008; McArthur, 2010; Perriton & Reynolds, 2004; Shudak, 2014). Critical pedagogy was initially oriented towards a phenomenological perspective with a focus on the agent, her/his agency, and the lived experience of the individual as co-constitutive in the production of meaning. More recently, some branches of critical pedagogy have focused on creating a shared understanding between individuals, and between students and teachers that could result in action and change (Giroux, 2004, 2007; Harden, 1996; Jackson, 1997; Perriton & Reynolds, 2004; Shudak, 2014). Educators who adopt a critical pedagogical stance focus on examining and critiquing the reproduction of power, at the same time articulating the emancipatory potential of education and this approach enabled me to delve more deeply into the issues that participants brought forward.

Critical pedagogy is theoretically grounded in critical social theory and Marxist ideology (Harden 1996; Ironside, 2001; Kincheloe, 2008; Ornstein & Hunkins, 1993; Perriton &
Critical social theory advances the notion that the purpose of education is to enable individuals to become aware of the socio-political-economic context of their situation thereby enabling individuals to problematize issues and organize socially in order to create change in society.

A fundamental premise of Marxist pedagogy is that schools and institutions in society function in part to maintain and reproduce power within an exploitative capitalist system (Braa & Callero, 2006; Giroux, 2007; McAllister, 2005a, 2005b; McLaren & Kincheloe, 2007). The reproduction of power, also known as bourgeois hegemony (Braa & Callero, 2006), is not always obvious to the majority of people in society and usually involves implicit control through consent. The reproduction of power emerged as an important data code and is described further in the Results chapter.

I have integrated ideas from critical theorists such as Pinar (1975, 2004), Giroux (2004, 2007), Frieire (1998), and bell hooks (1994, 2015) in my teaching practice, as each provides a particular way of conceptualizing critical pedagogy in her/his work. For instance, bell hooks examines the socio-economic political impact on individuals’ choices from the perspective of race, gender, and class-the same factors present in nursing and nursing education. Although each author forwards unique viewpoints, most agree on some fundamental assumptions that support critical pedagogy.

The main assumptions that underpin critical pedagogy are centred on equality, liberation, hope, and raised consciousness in shaping individuals’ lives through identifying and acknowledging the structural constraints that they encounter (Braa & Callero, 2006; Giroux, 2010b; Jackson, 1997; Kincheloe, 2008; McAllister 2005a; Naiditch, 2009; Perriton & Reynolds, 2004; Rafferty, 2011). Educators using a critical pedagogical approach are concerned with issues of oppression, injustice, and inequality, and they seek to build in their students a consciousness of how such inequalities are developed and how they are maintained within the particular social context.

In critical pedagogy, construction of knowledge encompasses the individual’s experience and her/his meaning of the experience. Meaning is an important element as it influences the person’s identity, outlook, and being in the world. A critical epistemology assumes that the “mind creates rather than reflects, and the nature of this creation cannot be separated from the surrounding world” (Kincheloe, 2008, p. 28). In this theory, knowledge emerges from a
dialectical relationship between the knower and the known, between the subject and the object, between the teacher and the student where both are engaged in learning, posing questions, reflecting and co-constructing meaning of the text under examination. Furthermore, critical theorists scrutinize the validity of claims that consider only certain types of knowledge, such as scientific truths and objective knowledge as sound and therefore legitimate. Instead, critical theorists propose that educators focus on diverse epistemologies and forms of knowledge that are forwarded and/or excluded from discourse. In using a critical pedagogical lens, I was able to frame and conceptualize the many forms of knowledge portrayed by participants and also examine more deeply the constraints that negatively impacted their teaching practice.

2.4.1.1. Critical pedagogy and instruction.

Critical pedagogy enables teachers to reframe their work, become co-producers of knowledge, and co-construct with students their meaning of learning thereby empowering all. Critical theorists such as Kincheloe (2008) posit that teachers are not “managers of predetermined knowledge of dominant cultural power” (p. 9), nor do they function to develop methods to efficiently transmit predetermined knowledge. In using a critical pedagogical approach, the focus of teaching remains on developing the individual and in promoting social justice and democracy. For instance, in my lesson plan on respiratory conditions, instead of focusing solely on the pathophysiology of the illness as found in the prescribed curriculum, I provide space in my lesson plan for dialogue, and guide students to think about the person with the condition and how that patient copes with her/his illness. In doing so, I hope that students develop a broader and deeper understanding of the person with the disease as well as a comprehensive understanding of their role as a student nurse.

Teachers adopting a critical pedagogical stance tend to use generative themes, thus focusing not just on the content, but on the impact of the content thereby enabling students to “read the world instead of just focusing on the word” (Bertoff, 1990; Friere, 1998; hooks, 1994, 2015; McLaren & Kincheloe, 2007; Naiditch, 2009). Reading the word is more than merely reading the text; it is an interactive process between the reader and the text where the reader constructs meaning based on her/his personal experiences, context, and situation. Critical educators guide students in reading behind the text, searching for assumptions, meaning, context, and/or posing questions. In doing so, educators enable students to understand and analyze problems more deeply and, at the same time, reach higher forms of cognition. For instance, the
description of enteral feeding in the prescribed nursing curriculum focuses solely on the pathophysiology of the condition and the skills associated with enteral feeding. It does not fully reflect the reality that students encounter in their practice particularly in relation to the ethical aspects related to enteral feeding and the complex issues arising from situated knowledge in practice. Also, by merely reading from the textbook and/or from predetermined power point slides we limit the possibility of discussion and dialogue which are both important features in the development of knowledge.

Generative themes are compelling and controversial topics taken from students’ knowledge of their own lived experiences, saturated with emotion and meaning thereby eliciting commitment and the excitement of learning (Kincheloe, 2008, p. 11). Generative lessons encourage students to raise questions and connect their learning to issues in the real world. In such a learning environment, teachers and students negotiate their understanding of the content; teachers support students to develop their analytical and interpretive skills and their knowledge. In this manner, students learn to “distinguish between the oppressive and liberatory ways of seeing the world and themselves…[they are] able to identify forms of faux-neutrality that permeate the epistemology of schooling…[and] are empowered to pick out the unexamined assumptions and hidden philosophical beliefs that shape the official standardized curriculum” (Kincheloe, 2008, p. 13). For instance, nurse educators by linking students’ clinical experiences to nursing content enter into dialogue with students, enabling students to pose questions and link their knowledge to their nursing practice. In developing critical awareness, critical educators provide space for dialogue and debate in the classroom, which in turn provides the potential for change in student perspectives and actions.

A teacher adopting a critical pedagogical stance engages students through dialogue and discourse, and thereby co-learning and co-creating with students their meaning of learning and being in the world (Bertoff, 1990; Breunig, 2005; Freire, 1998; Giroux, 2004, 2007, 2010a, 2010b; Jackson, 1997; McArthur, 2010; Naiditch, 2009). Teachers and students are encouraged to examine their personal assumptions, beliefs about their situation and the world around them, and make conscious decisions about the persons they want to be and about their relationships with others in the world.

Critical educators simultaneously use elements such as dialogue, critique, praxis, and counter hegemony in their practice (Braa & Callero, 2006; Harden 1996; McLaren & Kincheloe,
2007; Sleeter, Torres, & Laughlin, 2004). The four elements are interrelated and intertwined, and they work concurrently in exposing and addressing injustice, inequality, and oppression in society. In such classrooms, students and teachers participate in discussion and dialogue, the expert knowledge of the teacher becomes decentred, and students’ concerns and interests become part of their learning. Students develop social consciousness through dialogue with others, and they may overcome the culture of silence and acquiescence that permeates traditional classrooms.

In creating spaces for dialogue in the classroom, critical educators enable students to critique existing conditions and unmask the ways of seeing the “world and the word” that undermine their own and others’ best interests. The critical educator works with students in developing their individual talents and abilities invisible to others thereby providing the opportunity for the development of each individual.

Educators adopting a critical pedagogical stance engage in praxis (Freire, 1998; Grollios, 2009; Holst, 2006). Freire coined the term *praxis*, which describes continuous cycles of thought, reflection, and action (Naiditch, 2009) in their teaching. By engaging in praxis, teachers become aware of the changes required and apply their knowledge in creating change more broadly in society. Application of knowledge in creating change is an important aspect of becoming aware, as thinking without action is described by Friere (1998) as merely wishful thinking. Reflection and thinking about all aspects of practice are essential and contribute to the development of an educator’s practice. Critical pedagogy requires teachers to adopt a critical reflexive approach thereby “bridging the gap between learning and everyday life, and understanding the connection between power and knowledge” (Giroux, 2004, p. 34). Reflection and thoughtful examination of issues enables educators to examine the influence of power, its context and conditions that perpetuate its influence.

Furthermore, Giroux (2004) adds, the authority that a critical educator displays is directive but open, critical but not closed, must be vigilant and self-conscious about its promise to provide students with a public space where they can learn, debate…in order to expand their own sense of agency while simultaneously developing those discourses that are crucial for defending vital social institution as a public good. (p. 43)
Giroux shares important insights for teachers to consider as he focuses on the “How” of teaching. In this study, the how of teaching and manner of the teacher emerged as an important result and is further examined in the “Discussion” chapter of this thesis.

2.4.2. Critical Pedagogy and Freire.

While Freire subscribes to most of the assumptions that underpin critical pedagogy, he emphasizes that educators need to examine the broader social context that influences learning. Freire focuses on the conditions and context surrounding people’s lives, on social structures that constrain their choices and has written extensively on transforming education for the benefit of adults and children. One of Freire’s key messages centres on the notion of consciousness (Freire, 1998; Sleeter et al., 2004). Consciousness is “constituted in the dialectic of man’s objectification of and action upon the world…consciousness is never a mere reflection of, but a reflection upon material reality” (Freire, 1998, p. 500). Freire explains that individuals (both women and men) have the ability to gain distance from their surroundings, and in doing so are able to critically reflect on their surroundings and context, their actions and interactions; they are able to imagine and plan goals for themselves, thereby transforming their presence in the world. The ability of individuals to think, imagine, reflect, and plan empowers the individual in determining her/his freedom. Freire’s belief that individuals have the ability to change their situation influenced his views on education and the role that teachers play in this process.

Freire coined the term conscientization, which means becoming aware, a process in which “men’s consciousness, although conditioned, can recognize that it is conditioned. This critical dimension of consciousness accounts for the goals men assign to their transforming acts upon the world” (Freire, 1998, p. 501). Conscientization involves a process of listening and naming, reflecting and awakening, entering into dialogue and discussion with others, which has the potential to lead to transformative action (Bertoff, 1990; Sleeter et al., 2004). Dialogue is not just any social conversation; it is a close encounter between individuals comprising dialectical and reflective elements (Bertoff, 1990). Individuals, by engaging in dialogue, can begin to decode the meaning of their context and begin to develop their consciousness and reality in a systematic way. Decoding refers to the description of the situation, its particularities as perceived by the individual, and the institutions that shape those conditions (Sleeter et al., 2004).

Freire (1998) states that the goal of education should equip students to think critically and raise questions. He states that education processes such as a standardized curriculum and scripted
pedagogical practices maintain and reproduce the goals of education in the production of labour. Instead, Freire instructs teachers to examine how the “set curriculum” influences students’ thinking and advises teachers to provide opportunities for students to change or influence curricular decisions.

Freire suggests that educators consider adopting a problem posing pedagogy where “education should help students achieve a critical understanding of their own reality and to engage in transformative actions” (Sleeter et al., 2004, p. 82). By naming the problem, individuals examine the issues critically using varied lenses thereby improving their understanding of the problem and collaborating with others in seeking alternative solutions.

Freire (1998) encourages teachers to become aware of the knowledge, skills, and lived experiences that students bring to schools in order to transform the learning experiences of students. Experience is the starting point and becomes an object of inquiry that can be affirmed, interrogated, and used to develop broader knowledge and understanding. Friere shares similar sentiments espoused by Dewey in focusing on the student’s experience (Mitchell et al., 2012), thereby decentering the teacher’s central authority and enabling learning to occur.

From an epistemological viewpoint, both Dewey and Friere advocate that schools should move away from a mechanistic, reductionist curriculum and scripted pedagogy with its emphasis on transference of information as “learning and knowledge is far too complex to treat it in a degraded manner” (Kincheloe, 2008, p. 12). Both education scholars focus on engaging students in order for learning to occur. I have found both scholars’ viewpoints relevant and informative to my understanding of curriculum development and pedagogy in nursing.

Freire (1998) shows how the dominant class focuses on systematically reproducing its own ideology by influencing curriculum. Specifically, he describes how the imposition of curricula on teachers ensures that the teacher remains preoccupied with covering content rather than raising queries about broader social and political conditions that influence learning. As the amount of curriculum content increases, the teacher struggles ever more to cover content rather than on questioning the ideology that underpins curriculum thereby perpetuating the status quo. To counteract this often invisible process, Freire encourages teachers to become aware of the influences that shape or constrain their actions. Freire’s ideas have relevance for nurse educators as they develop nursing curricula and pedagogy and I draw upon some of the ideas forwarded by Freire in the “Discussion” chapter.
Summary of chapter.

In this chapter I have drawn on important issues in nursing education and introduced more broadly concepts from teacher education in order to situate important elements that emerged from the data. I explained my rationale four using the term *pedagogy* throughout this thesis and described two approaches to instruction in order to situate important concepts that emerged from the data.
Chapter 3.0. Methods

Overview of Chapter

I begin this chapter with the two broad research questions that guided this inquiry, detail the particular grounded theory approach used in this study and my justification for doing so. I then provide a brief overview of the evolution of grounded theory and finally, describe the methods used in this study for the collection and analysis of the data and the criteria used for evaluating rigour in this study.

The term “method” pertains to the specific procedures or techniques that a researcher utilizes in obtaining and analyzing data whereas the term “methodology” describes the general logic and theoretical perspective of a research project (Bogdan & Biklen, 2010; Corbin & Strauss, 2008; 2015). I first describe the research methods used in this study, a grounded theory approach forwarded by Charmaz (2010) and then situate this approach within a broader research perspective.

3.1. Research Questions.

In grounded theory methodology, the researcher begins the inquiry by posing broad questions and continues to develop and frame questions during the data collection process in order to delve more deeply into emerging issues.

The two research questions guiding this study were as follows:

1. How do clinical nurse educators approach teaching undergraduate student nurses in the clinical arena?
2. What challenges do clinical nurse educators encounter while instructing undergraduate student nurses in the clinical arena?

3.1.2. Justification for Using Grounded Theory Methodology In This Study

In planning this study, I considered several different methodological approaches such as grounded theory, case study, and phenomenology and chose to utilize a grounded theory approach. Grounded theory seemed the most appropriate because it is a method used to investigate social problems or situations where little is known about the problem or to provide another view on existing knowledge or where people have to adapt according to the context (Denzin & Lincoln, 2011; Goulding, 1998; Mills, Bonner & Francis, 2006b). Using this method, researchers move beyond the individualist, person-by-person experiences and generate a theory at a broader conceptual level.
Grounded theory approach is an appropriate approach as little is known about the pedagogical practices of clinical nurse educators or the challenges that they encounter while instructing in the clinical arena. Furthermore, their voices and experiences in teaching are largely missing from the nursing education literature.

3.2 Grounded Theory.

A researcher’s philosophical perspective is a reflection of a researcher’s beliefs and values that guide her/him in interpreting the data (Annells, 1996; Hall, Griffiths, & McKenna, 2013) therefore, researchers should select a research paradigm that closely reflects their beliefs by examining the ontological, epistemological, and methodological stance of the paradigm under consideration. I first describe the ontology and epistemology that underpins grounded theory in general and then describe the assumptions that underpin grounded theory forwarded by Charmaz (2010) in particular in order to make visible the assumptions that underscore this study. The term ontology pertains to one’s understanding of the nature of reality; whereas epistemology describes the relationship between the researcher and participant and what counts as knowledge in a particular context. Methodology relates to the methods and/or procedures employed to discover knowledge about the problem under investigation (Annells, 1996; Hall et al., 2013). Each term in interlinked and interdependent, guiding and informing the other.

Grounded theory has evolved over time and reflects the influence of the various philosophical thought of its proponents (Denzin & Lincoln, 2011). Grounded theory was originally developed in the 1990s by Glaser and Strauss with the intention of developing theoretical explanations about human behaviour grounded in the data (Annells, 1996; Chen & Boore, 2009; Creswell, 2007; Cutcliffe, 2000; Denzin & Lincoln, 2011; Glaser, 2002; Glaser & Strauss, 2005; Goulding, 1998; Hall, Griffiths &McKenna, 2013; Mills et al., 2006a, 2006b; Mills, Chapman, Bonner, & Francis, 2007; Punch, 2009). Prior to the emergence of grounded theory, much of the research focused on hypothesis testing and verification of existing theories and Glaser and Strauss developed grounded theory as a “reaction against the exclusive insistence on theory verification research” (Punch, 2009. p 132). Currently, the main proponents of grounded theory are Glaser and Strauss (2005), Corbin and Strauss (2015), and Charmaz (1990, 2010, 2017). In this study, I utilize a modified grounded theory approach forwarded by Charmaz and will discuss this approach a bit later in this section.
Grounded theory focuses on the systematic generation of theory drawn from an analysis of data that documents the meanings of events and/or interactions of individuals and the language they use to convey those meanings (Annells, 1996; Corbin & Strauss, 2008, 2015; Charmaz, 2010, 2011; Denzin & Lincoln, 2011; Glaser, 2002; Glaser & Strauss, 2005; Mills, et al., 2006a, 2006b; Punch, 2009). A theoretical explanation of a process or a practice is generated from the emergent data.

Grounded theorists aim to discover and explain how individuals understand their reality. The generation of a theory evolves throughout the research process and is a product of continuous back-and-forth between data collection and analysis using a combination of deductive and inductive approaches (Breckenridge, 2012; Charmaz, 1990, 2010; Corbin & Strauss, 2015; Denzin, & Lincoln, 2011; Glaser & Strauss, 2005; Goulding, 1998; Hall et al., 2013; Mills et al., 2006b; Sandelowski, 1993a).

By the 1990s, two schools of grounded theory emerged (Annells, 1996; Breckenridge, 2012; Chen & Boore, 2009; Cutcliffe, 2000; Goulding, 1998; Hall, et al., 2013; Mills et al., 2006a: Mills, Chapman et al., 2007). One school was led by Glaser, and the other was led by Strauss and Corbin. Glaser’s research approach is known as traditional or Glaserian grounded theory, and the approach of Strauss and Corbin is known as Strauss–Corbin or the revisionist approach.

3.2.1 Differences in Grounded Theory between Glaserian and Revisionist Approaches

The three main differences between the Glaserian and the revisionist approach pertain to the conceptual orientation of each approach, the timing of the literature review, and the analytic tools used in the inquiry.

3.2.1.0. Conceptual orientation.

From the very beginning, grounded theory drew upon conflicting and divergent philosophical assumptions. Glaser’s background in structural-functionalism and Strauss’s pragmatic approach led to a vague and generalized approach in ontology and epistemology of traditional theory, also known as classical grounded theory (Denzin & Lincoln, 2011; Hall, et al., 2013). This is the first difference.

In traditional or Glaserian grounded theory, the “ontological lens is oriented towards critical realism, a modified objectivist epistemology, with an associated methodology aimed at theory discovery that may be subsequently verified by research” (Annells, 1996, p. 389). The
assumptions that underpin a modified objectivist approach are that the researcher tries to continually be aware of her/his relationship to the data and sets up a strict separation from the data by following stringent procedural directions during data collection and analysis (Annells, 2006).

Unlike the newer versions of grounded theory, traditional grounded theory forwarded by Glaser is firmly situated in a post-positivist paradigm (Annells, 1996, 2006; Bogdan & Biklen, 2010; Charmaz, 1990; Chen & Boore, 2009; Denzin & Lincoln, 2011; Goulding, 1998; Hall et al., 2013; Mills et al., 2006b).

Strauss, on the other hand, was greatly influenced by the works of John Dewey and George Mead, and his theory reflects a combination of these two philosophies—the philosophy of pragmatism and the philosophy of interactionism (Corbin & Strauss, 2015). Two of Strauss’s assumptions were that “there is no one truth” and that “the external world is a symbolic representation, a symbolic universe” (Mills, Chapman et al., 2007, p. 74).

Strauss and Corbin’s approach, with its focus on elaborate coding frameworks and verification procedures, vacillates between a post-positivist and a constructivist paradigm (Denzin & Lincoln, 2011; Hall et al., 2013). Strauss and Corbin insist that “reality exists only as multiple mental constructions” (Annells, 1996, p. 386) and that reality is always interpreted. From an epistemological standpoint, the approach supports the interactive nature of the researcher and the participant in a dyad relationship and adopts a subjectivist’s viewpoint (Annells, 1996; Chen & Boore, 2009; Corbin & Strauss, 2015; Denzin & Lincoln, 2011; Hall et al., 2013; Mills et al., 2006a, 2006b; Mills, Chapman et al, 2007).

Strauss and Corbin acknowledge that researchers are actively engaged with the data throughout the research process, and suggest that researchers draw on their experiential knowledge of the topic during data collection and when formulating hypotheses (Annells, 1996; Chen & Boore, 2009; Hall et al., 2013; Mills et al., 2006a). They focus on the co-construction of meaning between researcher and participant and state that “interviews are not neutral context-free tools for data collection… they provide the site for active interactions between two people leading to results that are both mutually negotiated and contextual” (Mills et al., 2006a, p. 9).

I considered the epistemological stances forwarded by Glaser and by Strauss and Corbin and decided to use the approach forwarded by Charmaz. I detail my reasons for adopting this approach in the section below titled “Grounded Theory by Charmaz.”
3.2.1.1. Literature review.

The second difference between a Glaserian and a revisionist approach relates to the timing of the literature review. Glaser suggests that the review of the literature prior to data collection could lead to “contamination, constraining, inhibiting the researcher” (Mills et al., 2006b, p. 29) and result in a premature closure of ideas (Chen & Boore, 2009). Glaser suggests that researchers delay conducting a review of the literature until they have a good grasp of the participants’ views in order to develop themes from the data.

Strauss and Corbin, on the other hand, suggest that researchers conduct a preliminary review of relevant literature in order to obtain conceptual clarity of the problem under investigation (Charmaz, 1990, 2010; Chen & Boore, 2009; Corbin & Strauss, 2015; Denzin & Lincoln, 2011). However, once a theory emerges from the data, all grounded theorists suggest that researchers conduct a literature review to situate categories and concepts within the existing literature (Charmaz 2010; Chen & Boore, 2009; Corbin & Strauss, 2015; Cutcliffe, 2005). The literature review is then used to explain the new emerging theory.

In this study I conducted a preliminary review of the literature as suggested by Charmaz in order to formulate broad research questions. On collecting and analyzing data, I began to formulate main codes and sub-codes. Once data saturation of the main codes and sub-codes was achieved, I reviewed the literature in light of concepts that emerged from the data.

3.2.1.2. Analytic measures.

The third difference between the Glaserian and the revisionist approach pertains to the analytic tools used to scrutinize the data. Glaser offers a more flexible analytic approach whereas Strauss and Corbin detail many different types of coding measures, such as axial and matrix coding (Denzin & Lincoln, 2011; Goulding, 1998). Regardless of the analytic tools utilized in a study, the purpose of coding in grounded theory remains the same: it enables researchers to build a middle-range theory from their data.

It was the differences in the ontology and epistemology of the Glaserian and revisionists approach that led me to consider using Charmaz’s approach to grounded theory in this study. Additionally, I found that using a Glaserian approach was limiting as it focuses on the separation of the researcher from her/his data. As a nurse educator teaching in the classroom and the clinical arena, I found this separation to be artificial and therefore problematic.

3.2.2. Grounded Theory by Charmaz
I found that a modified grounded theory approach by Charmaz enabled me to examine and explore in greater detail the issues that arose from my research data. Using this particular lens of grounded theory, I was able to examine structural and organizational processes that enhanced or impeded participants in their teaching in the clinical arena.

I provide a brief overview of grounded theory forwarded by Charmaz and focus on the conceptual orientation of the approach and analytic tools used in this approach.

### 3.2.2.1. Conceptual Orientation in this approach.

Charmaz (2010) further developed the ideas forwarded by Strauss and Corbin and moved the grounded theory approach more deeply into a constructivist perspective (Breckenridge, 2012; Mills et al. 2006a; 2006b). Also, Charmaz was the first researcher to explicitly name her work as “constructivist grounded theory” (Mills, Chapman et al., 2007, p. 74). A constructivist approach subscribes to the broad assumptions found in an interpretive paradigm that is described in detail in the subsequent section. She adds that analysis is created from shared experiences and relationships of the researcher with the participants. Researchers using an interpretive approach emphasize patterns and connections amongst categories in the data. This type of theory assumes “emergent, multiple realities; indeterminacy; facts and values as inextricably linked” (Charmaz, 2010, p. 127). This method is congruent with Mead’s symbolic interactionism approach which is described in more detail in the subsequent section.

Charmaz (1990) describes her approach to grounded theory as “a symbolic interactionist perspective tempered by Marxism and phenomenology” (p. 1161). This approach enables researchers to look closely at the “participant’s interpretation of the situation…[and] actions” while “Marxist theory provides an avenue to link the individual’s choice to larger social structures and enables the researcher to ask critical questions about how society/ institutions impinges upon the individual and how individuals reproduce dominant ideas within society” (p. 1161). This approach enables researchers to learn how, when, and to what extent the “studied experience is embedded in larger and often hidden position networks, situations and relationships. The difference and distinctions between people become visible as well as the hierarchies of power and communication that maintain and perpetuate such differences and distinction” (Charmaz, 2010, p. 130).

Charmaz states that a constructivist approach is important in analyzing data “because data do not provide a window on reality. Rather the ‘discovered reality’ arises from the interactive
process and its temporal, cultural and structural contexts” (Charmaz as cited in Mills et al., 2006b, p. 31). The epistemological lens in this approach subscribes to a reciprocal relationship between participant and researcher where both contribute to creating meaning and a theory emerges grounded in their experiences. Instead of discovering theories, the researcher constructs knowledge from the data (Hall et al., 2013; Mills et al., 2006a). In using a constructivist approach while conducting interviews, I was able to delve more deeply into the teaching experiences of participants. For instance, when participants mentioned the stress that they experienced when instructing students to administer medications, I was able to delve more deeply about their teaching context. A constructivist approach enabled me to examine and contrast each participant’s experience in teaching students about safe medication administration as well as guide me in creating new interview guides for subsequent participants.

In addition, a constructivist approach in this study design aligns and supports the constructivist lens used to theorize participants’ approach to their teaching in the clinical arena. Using a constructive lens in both research design and analysis adds further coherence to the results.

Charmaz (2010) adds that a researcher’s viewpoint is considered within the theorizing process, and she explains the term “theorizing” as a process, a practice. Theorizing enables the researcher to ponder, “rethink anew, establish connections and ask questions. In theorizing one reaches from fundamentals to abstractions and probes new experiences” (p. 135), avoiding importing and imposing pre-packaged images and ideas on the data.

3.2.2. Analytic Tools used in this approach.

Although Charmaz uses similar analytic tools described by Glaser and by Strauss and Corbin, the author advocates a flexible approach and reminds researchers to focus on the data rather than strictly adhering to coding procedures (Mills et al., 2006a).

3.2.3. Difference between Charmaz and Strauss and Corbin

One of the main differences between Charmaz and the revisionist approach lies in the outcome of the research project. Charmaz focuses on explaining multiple perspectives and exploring complexities of views and actions while Strauss and Corbin focus on predicting and controlling outcomes (Bogdan & Biklen, 2010; Corbin & Strauss, 2015).

3.2.4. Theoretical Assumptions Found in Grounded theory.
Grounded theory draws on certain assumptions from broader and more diverse theories such as social constructivism. A constructivist approach enabled me to delve more deeply into the pedagogical practices of the participants, and to understand and explain the factors that enhanced or constrained the participants’ teaching activities in the clinical arena. Furthermore, this approach supports a critical pedagogical lens that underpins this study bringing coherence to the general logic and design of this study.

I now delve further into the theoretical assumptions that underpin a social constructivist viewpoint and where the nature of reality is local and relative; it is mentally constructed by an individual or a group of individuals within a particular context (Creswell, 2007; Bogdan & Biklen, 2010; Broido & Manning, 2002; Goulding, 1998; Hall et al., 2013; Mills et al., 2006b). From an epistemological standpoint, the knower is subjectively and interactively linked in relationships to what can be known (Annels, 1996) and the researcher inductively develops patterns of meaning from the data. Methodologically, “the researcher engages in the inquiry process that creates knowledge through interpreted constructions via dialogue” to provide a reconstructive understanding of the problem under examination (Annels, 1996, p. 385). Also, a methodological theory relates to the methods and/or procedures employed to discover knowledge about the problem under investigation (Annells, 1996; Hall et al., 2013; Punch, 2009) and guides the researcher in their interpretation of the data.

3.2.4.1. Symbolic Interactionism Paradigm.

A social constructivist approach draws upon assumptions found in symbolic interactionism (Annells, 1996; Bogdan & Biklen, 2010; Denzin & Lincoln, 2011; Goulding, 1998), and I now delve into that literature in order to explain the interpretive nature of this study. Symbolic interactionism is both a theory about human behaviour and an approach to an inquiry into an individual’s conduct and/or group behaviour. George Mead, the theory’s earliest proponent, stated that an individual defines her/himself through social roles, expectations, and perspectives given by others in society (Annels, 1996; Bogdan & Biklen, 2010; Chen & Boore, 2009; Cutliffe, 2000; Hall et al., 2013; Mills, et al., 2006b). Knowledge is created through action and interaction of self with others in society, and Mead postulated the individual as a reflective being. Similar sentiments were espoused by other philosophers at the time, one being John Dewey, a philosopher in education.
Subsequently, Blumer refined Mead’s theory (Hall et. al, 2013) and postulated three basic premises that underpin symbolic interactionism. They are (1) the meaning that an object/situation/ institution has for a person will determine the individual’s action, (2) meaning is derived from social interactions, and (3) an interpretive process is used to direct and modify the meanings of the situation as perceived by the person (Annels, 1996; Hall et al., 2013).

In symbolic interactionism, the meanings of symbols are a product of an interpretive experience between oneself and others. Language is the most common symbol. For instance, in an interaction, each person attaches meaning to various aspects of the encounter based upon symbols that might be shared between them. Although some individuals sharing a symbolic interactionist viewpoint disagree with Blumer’s premise, meaning, and interpretations remain key elements of a symbolic interactionist approach.

In summary, I discussed the evolution of grounded theory and some important features found in each approach. Also, I located grounded theory within a broader theoretical framework in order to further situate this study within a particular research paradigm.

3.3. Participants

In this section, I describe the methods employed in this study as they relate to the number, recruitment, and selection of participants. In the next chapter, I describe some important characteristics about this group of participants that emerged from the data.

3.3.1. Number of Participants

I recruited a total of thirteen participants; one participant withdrew during the first interview due to personal reasons, leaving twelve who participated in the first round of interviews.

Another participant could not participate in the second round of interviews due to personal commitments, thus I interviewed eleven of the participants twice, conducting a total of twenty-three interviews over the course of eight-nine months.

3.3.1.1. Strategies for the Recruitment of Participants.

I used the following four strategies to recruit participants:-(1) Advertised in a local professional journal that is read by most nurse educators; (2) Held information sessions for clinical nurse instructors and informed them of the study; (3) Used a snowball technique to recruit potential participants (a snowball technique is where one individual contacts another to participate in the study); and (4) I contacted the deans or chairs of the five undergraduate nursing
programs in Toronto, Canada, by email and telephone and asked to meet with them or their
designate in order to inform them of the study. I made these contacts repeatedly at first and then
at periodic intervals. Only one chair of one nursing program responded. The lack of interest by
heads of nursing education departments in this research topic is problematic.

3.3.1.2. Strategies for the Selection of Participants.

I used the three sampling strategies to select participants in this study. They were
purposeful sampling, criterion sampling, and maximum variation approach to screen and select
participants and all three approaches are commonly used by researchers using grounded
methodology (Chiovitte & Piran, 2003; Cutcliffe, 2000, 2005).

3.3.1.2.1. Purposeful sampling. I used a purposeful sampling strategy to select nurse
educators with teaching experience of between three-and five years in the clinical arena; nurse
educators with this level of experience would provide richer information about the research
problem. Additionally, purposeful sampling increases theoretical sampling in the data (Chen &
Boore, 2009; Corbin & Strauss, 2015; Creswell, 2007; Cutcliffe, 2000).

3.3.1.2.2. Criterion Sampling. I also employed a criterion sampling method where
clinical nurse educators who met a certain number of predetermined criteria-such as having
received a graduate degree in nursing; having taught in different settings such as acute care,
chronic or community care; or having cared for a variety of patient populations such as pediatric,
maternal-child-were invited to participate in the study. These criteria allowed me to accept or
reject participants fairly.

3.3.1.2.3. Maximum Variation approach. Additionally, I used a maximum variation
approach that consisted of determining criteria in advance thereby increasing the likelihood of
hearing different perspectives (Cutcliffe, 2000; Creswell, 2007; Polit & Beck, 2004). For
instance, I included participants from varied ethnic backgrounds, recruited male participants, and
recruited participants who taught in more than one undergraduate nursing program in order to
increase the variability of contexts, thereby generating a more robust understanding of the nature
and extent of the problem.

3.3.2. Inclusion Criteria

I determined the following three inclusion parameters for participant selection: (1) all
participants were clinical nurse instructors and taught in the clinical arena; (2) all taught in
undergraduate nursing programs; and (3) all taught for more than three years. Studies have
shown that, as nurses’ transition into teaching (Boyd, 2010; Boyd & Lawley, 2009, Dinkelman, Margolis & Sikkenga, 2006); they are often overwhelmed with the new role. Therefore, having participants with longer experience in teaching ensured that they could better inform the research questions.

3.3.3. Exclusion Criteria

Nurse educators that were indirectly involved in teaching in the clinical arena such as nurse educators working in a preceptored model were excluded in this study. In a preceptor model, a student nurse works closely with a staff nurse and a nursing faculty member oversees the student. A number of different variables come into play in a preceptor model; therefore, to maintain clarity of the problem under investigation, I decided that only those nurse educators involved with direct instruction could participate in the study.

3.4. Data Sources and Methods

In this sub-section, I describe the methods related to the collection of data, interviews and analytic tools used in coding the data and data management procedures used in this study. Data sources in this study included taped interviews, transcripts, memos and my field notes. I integrated my insights, observations, and interpretation of the participants’ teaching context in my memos and field notes and that too became part of the data source. I transcribed all the participants’ interviews, my field notes and recorded memos. The analysis of these sources includes the thought process in assigning and reassigning meaning to the data.

3.4.1. Location and Duration of Interviews

Each of the twelve participants worked independently as clinical nurse educators and were able to determine a convenient time and location for the interview. I conducted face-to-face interviews with eleven participants and interviewed one participant over Skype. A total of twenty-three interviews were conducted in quiet locations such as the library at the university, classrooms, and at convenient locations for the participants. I could not conduct an interview with one participant due to multiple conflicts in scheduling.

All the participants took the entire hour to share their thoughts; some took more than the allotted time; and yet another participant provided me with notes about her thoughts.

The participants were appreciative of being given the opportunity to share their thoughts and recommendations. A few participants mentioned that the questions provoked a good amount of self-reflection and pondering, and stated that they had enjoyed sharing their insights with me.
3.4.2. Interviews

Interviews play a central role in collecting data in studies utilizing interpretive paradigms such as grounded theory (Creswell, 2007; Rowley, 2012). I interviewed each participant twice and the purpose of doing so was twofold. In the first interview I asked broad questions to elicit information about the problem being studied. In the second interview, I delved more deeply into issues; sought clarification on some categories that I did not fully understand (member-checking); made comparisons in the data as I developed and populated categories and checked for relevancy of the concept amongst participants using a constant comparison method. The purpose of an interview is to enable the researcher to gain understanding or insight into issues from a participant’s perspective (Bogdan & Biklen, 2010; Creswell, 2007; Cutliffe, 2005; Duffy, 2002; Duffy, Ferguson & Watson, 2002; Price, 2002; Rowley, 2012). After the fifth interview, I began examining the data for emerging concepts and developed new interview guides (Appendix 9.3) for subsequent participants.

Data collection continued until all categories were saturated. In data saturation, new data collection ceases once the researcher does not obtain any new information to shift or extend the categories and thus redundancy is achieved (Corbin & Strauss, 2015). During the second round of interviews and by the time I reached the fifteenth interview, although no new information emerged I continued to collect data in order to populate existing categories.

The interviews were semi-structured in nature and included both open-ended and close-ended questions. Semi-structured interviews allowed me to direct the conversation and explore the research questions with participants. In grounded studies, a researcher employs a number of methods concurrently such as open-ended questioning, constant comparison, and memoing (Corbin & Strauss 2015; Charmaz, 2010) in order to gather rich data. Open-ended questions enabled the participants to respond in their own words thereby giving voice to their experiences (Polit & Beck, 2004), and enabled me to collect and describe data using thick description. For the close-ended interviews, I prepared a list of questions in advance and asked each respondent the same set of questions. I used two types of close-ended questions. The first pertained to demographic data such as years teaching and types of clinical setting. I used this method on meeting each participant for the first time (Appendix 9.3). The second pertained to concepts that were emerging from the data. For instance, when a few participants mentioned the importance of
building relationships with students, I posed questions about the importance of this concept to subsequent participants.

During the later stages of the first interviews and throughout the second interviews, I used an unstructured and open-ended approach to questions thereby enabling each participant to direct the conversation in ways she/he felt were relevant to informing the problem under investigation. By having done so, participants freely added their thoughts on teaching in the clinical area. Because participants had the power to direct the conversation, new and related issues emerged—an important aspect of Charmaz’s approach to grounded theory.

3.4.2.1. Interview guide.

In developing the interview guide (Appendix 9.3), I used strategies such as laddered questions (Price, 2002) and question to break the ice—for example, “Could you describe a typical teaching day in the clinical arena?” Once the participants described their day, I posed open-ended questions based on their responses to elicit more information about specific teaching activities and other related issues. Laddered questions are an interview technique for selecting the most appropriate level of questions starting with the least invasive question first and proceeding to questions about deeper matter based on the premise that we need to build a safe relationship prior to delving into more sensitive issues (Price, 2002; Rowley, 2012). For instance, I began with questions about the common activities of being a clinical nurse educator, such as making student assignments, and then moved on to more complex and difficult topics, such as the challenges that participants encountered while teaching in the clinical arena.

3.4.3. Analytic Procedures Used in This Study

Although differences among grounded theorists have emerged over time, commonalities in methods related to categorizing of data remain. I provide a brief overview of the methods germane to grounded theory used in this study.

In grounded theory, researchers use an interactive, comparative, and iterative process where the researcher goes back and forth between data collection and analysis iteratively, as each informs and advances the other (Charmaz, 1990, 2010; Denzin & Lincoln, 2011; Glaser, 2014; Glaser & Strauss, 2005; Hall et al., 2013; Mills et al., 2006a, 2006b; Punch, 2009). The researcher asks questions and raises analytic questions during the iterative process thereby raising the level of theoretical analysis.
After interviewing the first five participants, I began to compare each transcript with the other and prepared additional interview guides for subsequent participants. For instance, when the first few participants mentioned the importance of ensuring that student nurses provide safe care to patients, I drafted an interview guide with open-ended questions to include this question, and asked this same question when interviewing subsequent participants thereby learning more about the importance of “safe patient care” to the participants.

In using a comparative and iterative process, the researcher interacts with the data by asking questions throughout the data collection and analytic process. The researcher takes the role of an active and engaged analyst (Charmaz, 2010, 2011; Denzin & Lincoln, 2011), interacting with participants, data, and emerging categories. For instance, participants mentioned a few factors that helped them learn how to teach. While one participant mentioned enrollment in formal education programs, another mentioned learning through trial and error, while yet a few others mentioned unlearning from their student experiences in order to learn new ways of teaching. I inquired about the term unlearning to teach with subsequent participants.

Furthermore, I used strategies that enabled me to analyze the data in more depth such as constant comparison, theoretical sampling, theoretical sensitivity, reflexivity and memo writing (Charmaz, 2010; Corbin & Strauss, 2015; Cutcliffe, 2000; Goulding, 1998). These techniques inform each other and enable the researcher to build an explanation from the data. The reflexive activities of the researcher underpin the interpretive nature of the study as evidenced in memos and field notes.

**3.4.3.1. Constant Comparison.**

In using a constant comparative method, the researcher continually asks questions and makes comparisons between and among participants’ responses in order to gain a more complete understanding of the data. The researcher compares data obtained from the participants and then progresses to making comparisons of her/his interpretation of the data; the interpretations are translated into codes and categories and these influence further data collection. This constant comparison of analysis grounds the researcher’s theorizing from the participants’ experiences by systematically generating a theory from the data (Chen & Boore, 2009; Cutcliffe, 2000; Goulding, 1998; Mills et al., 2006; Corbin & Strauss, 2015). For instance, one participant mentioned the importance of building a relationship with her students. On exploring this topic with other participants, I found that they used various words such as supporting and
encouragement to describe this activity. By engaging in this process of comparing the data between and amongst participants I was able to categorize, code, and develop the conceptual model in this study.

Also, a researcher’s tacit knowledge of the problem under investigation enables interplay between the investigator’s values and assumptions with the data to occur (Cutcliffe, 2000) and is consistent with the assumptions of symbolic interactionism. Therefore, methods such as constant comparison and memoing are checks used by investigators to ensure authentic representation of the data. In this study, I used the both methods to ensure that the sub-codes, five main codes and central concept emerged from the participants’ words and experiences.

3.4.3.2. Theoretical Sampling.

Theoretical sampling enables researchers to uncover and explore concepts at a deeper level and from many perspectives (Charmaz, 2010; Chen & Boore, 2009; Chiovitte & Piran, 2003; Corbin & Strauss, 2015; Cutcliffe, 2000; Goulding, 1998). The purpose of theoretical sampling is to illuminate and develop emerging categories and describe variations within the concept. The emerging concept then guides the researcher in developing new interview guides for subsequent participants and develop an emerging theory from the data. For instance, a number of participants mentioned the importance of building a relationship with their students. On examining their words and descriptions of the process, I developed a tentative concept of Building Partnership. I then developed questions about this concept and posed these questions to participants during the second interview in order to learn more about their process in building partnerships with student nurses.

3.4.3.3. Theoretical Sensitivity.

Theoretical sensitivity is premised on the researcher’s tacit knowledge and understanding of the research problem under examination whereby the researcher remains open to seeing new issues arise from the data (Chen & Boore, 2009; Corbin & Strauss, 2015; Cutcliffe, 2000; Glaser, 1978; Goulding, 1998; Neill, 2006). For instance, when I encountered sensitive issues such as when participants stated that they felt that they had no voice, I monitored my tone and my response to their situation. Also, I gently probed sensitive issues such as not feeling valued or not having a voice in the nursing program with the participants. Similarly, on recapturing particular experiences, some participants became visibly upset, at which point I provided a break in the conversation (Price, 2002; Rowley, 2012), to give them time to regain their composure.
Some grounded theorists consider reflexivity as embedded within theoretical sensitivity as it “emphasizes the reflexive use of self in the processes of developing research questions and analysis” (Hall & Callery, 2001, p. 263). As a nurse educator teaching in the clinical arena I had some idea of context and the problem under scrutiny. However, when participants mentioned the many challenges that they encountered in their practice, for example not having a voice, I pondered over the issue, reflected on its impact for both the individual and across participants while developing questions that I could pose to subsequent participants.

3.4.3.4. Reflexivity.

Reflexivity enables a researcher to scrutinize her/his decisions and interpretations in order to allow readers to assess how and to what extent the researcher’s interests and assumptions influence the inquiry (Charmaz, 2010). The purpose of reflexivity is to sustain objectivity. For instance in conducting this study and particularly during the interview process, I found that the experiences described by participants both informative and intriguing as they were somewhat different from my experience. Participants taught in settings such as paediatric; and or context such as in accelerated degree programs that were quite different from my teaching practice. So I needed to listen carefully in order to learn about their teaching context.

I used participants’ words and/or phrases to inform the descriptors, main and central concept. Also, I provided detailed excerpts in the participant’s voice so that readers could form their own views of the meaning of the data.

I have also clearly indicated my thoughts and voice in the “Results” chapter of this thesis to ensure separation between my thoughts and that of the participants. Similarly, when participants’ described situations that were clearly upsetting I reflected on my response during, immediately after the event and on transcribing the data. I used a memo format to audit my thoughts and impressions during data collection and analytic phases of this study. During the later stage of this study process I revisited these memos and compared my response to that of the participants.

In using a grounded theory approach forwarded by Charmaz (2010), which focuses more on co-construction of meaning, the separation between researcher and participant is less defined. Instead there is a reciprocal relationship between the investigator and participant, where both contribute to creating shared meanings (Mills et al., 2006a).
The researcher’s reflexive stance accounts for the relationship between the researcher and the participants (Cutcliffe, 2000; Hall & Callery, 2001; Mills et al., 2006a; Neill, 2006). Unlike the traditional hierarchal relationship between researcher and participant, in adopting a reflective stance the researcher becomes aware of the inherent power dynamic between researcher and participant and attempts to move towards a more equal position of power within the relationship (Mills et al., 2006a). For instance, I used unstructured interview process that enabled participants to direct the conversation and voice their concerns. By listening carefully to their experiences, I learned more about their teaching practice.

3.4.3.5. Memoing.

Memoing is a reflective process that provides researchers the opportunity to question, analyze, and make meaning during the interview and analysis process. There are many types of memos that serve a number of purposes (Charmaz, 2010; Corbin & Strauss, 2015; Elliott & Lazenbatt, 2005; Punch, 2009). Memos range from free writing and on-the-spot approach, to a more thoughtful and considered approach (Charmaz, 2010). I made a number of memos during the research process. For instance, after each interview I wrote or tape recorded my thoughts, observations, and impressions about the interview; on transcribing and reflecting on the data, I wrote another memo on my thoughts and ideas from the data. I found that memoing enabled me to draft questions for subsequent participants.

During the latter phase of analysis, I made more detailed memos as I compared responses between and amongst participants. Additionally, as I began to revisit each transcript, I included my ongoing thoughts and impressions of the data. Memos consisted of taped and recorded field notes and were transcribed verbatim.

3.4.4. Coding Measures Used in this Study

In grounded theory, data collection and analysis are not separate processes but occur simultaneously using an iterative and constant comparison approach (Charmaz, 2010; Corbin & Strauss, 2015; McCann & Clark, 2003, 2003b; Punch, 2009). I began analyzing the data after the fifth interview in order to develop further questions and explore the problem. Coding involves breaking down data into units of meaning, which were then categorized to generate concepts. Coding is the main link between collecting data and developing an emergent theory to explain the data; it shapes the analytic frame in order to build the analysis (Charmaz, 2010; Corbin &
Strauss, 2015; Cutcliffe, 2000; Goulding, 1998). I used the following coding strategies in varying degrees to analyze the data at different phases during the process.

3.4.4.1. **Line-by-line coding.** During the early phase of data collection I examined and coded the data using line-by-line and paragraph coding. I found that using gerunds (Charmaz, 2010) and the participants’ exact words and/or phrases such as *building a relationship* to categorize data very helpful. The initial codes enabled me to focus on areas of interests from the participants’ perspectives, compare data with data, and identify gaps in the data.

3.4.4.2. **Focused coding.** During the latter phases of the interviews and analysis process, I categorized the codes using focused, axial, and theoretical coding methods, and will describe each (Charmaz, 2010). In focused coding, the researcher uses the most frequent and/or earlier significant codes in the data to synthesize and explain large segments of data. The researcher then makes decisions about which focused codes carry analytic weight and can move the analysis forward (Charmaz, 2010; Corbin & Strauss, 2015). For instance, the situations related to medication administration that caused participants the most anxiety and stress became a focused code.

3.4.4.3. **Axial coding.** The researcher specifies the properties and dimensions of a category. For instance, in the code *partnerships*, a range of activities emerged from the data that included providing support to students and the use of threat by clinical nurse educators. Also, axial coding enables researchers to connect categories and subcategories together; frame questions on actions and consequences of action to subsequent participants (Charmaz, 2010; Corbin & Strauss, 2015; Punch, 2009). In this study, the use of axial coding enabled me to link broad categories such as *ethics in teaching* and *building partnerships* together.

3.4.4.4. **Theoretical coding.**

This is a higher level of coding as it specifies relationships between previously determined concepts and subcategories (Charmaz, 2010; Corbin & Strauss, 2015; Cutcliffe, 2000; Goulding, 1998). Theoretical codes aid in weaving the theory together. The theoretical codes are found in the conceptual framework of this study and detailed in the next chapter “Results”.

I also examined the data for process and contextual elements. The term process in grounded theory pertains to how and when individuals act or interact in order to solve a problem or reach a goal. The term indicates patterns of repetition, adaptation, or change (Corbin &
In this case, participants describe their process of change and adaptation in building a partnership with their students in the clinical arena.

The term context pertains to the actions and interactions of individuals within a given situation and the consequences of one’s action (Corbin & Strauss, 2015). For instance, the action of the participants when they encountered challenges and the consequences of their actions are captured in the concept pedagogical context, which emerged from the data.

I utilized both inductive and abductive reasoning in exploring the many realities that participants encountered, and by doing so developed a pattern of meaning from the data gathered. Inductive reasoning is where the researcher moves her/his understanding of the data from specific and concrete to more general and abstract. Abduction, a term coined by Charmaz (1990), denotes the process of researchers combining inductive reasoning during their interaction with the data.

### 3.5. Data Management

All participants were assigned a pseudonym known only to myself in order to protect their anonymity and confidentiality. All identifying data was delinked from the taped interviews and transcripts immediately upon transcription. The pseudonym code was used as a label for each recorded interview, transcription, and memo recorded during data collection and analysis. This information was kept in a locked file as per my research ethics protocol. Digital voice recordings of all interviews were downloaded to my computer, encrypted, and stored on my personal computer as per the research ethics protocol. Security measures for all study data were maintained as per the ethics protocol.

### 3.6. Ethical Consideration and Ethics Approval

The study received ethics approval from the Ethics Board, University of Toronto. As the participants were independent practitioners, the study was considered low risk and I received approval through an expedited process. Additionally, I sought ethics approval from a school of nursing where I held information sessions. Again, as the study was considered low risk, I received expedited approval.

Prior to recruiting potential candidates, I sent them an information letter outlining the purpose of the study, the time commitment, the risks and benefits of participating in the study, and my role as the interviewer (Appendix 9.1). I provided two information sessions, where I reviewed the purpose of the study, the risks and benefits to potential participants and answered
queries. I obtained informed consent from each participant prior to each interview and during the interview process as needed (Appendix 9.2). Participants were aware that they could decline to answer any questions at any time. Building a respectful and trusting relationship with each participant was very important to me as I realized the complexity of issues and the stress that accompanied the discussion of such important but difficult experiences.

One participant withdrew during the first interview due to personal reasons and her information was destroyed as per the ethics protocol. I maintained the confidentiality of each participant throughout the research process and assigned pseudonyms to ensure the anonymity of each participant. This information was kept in a locked drawer and shared only with my thesis supervisor.

3.7. Rigour In this Study

Determining rigour in qualitative studies such as a grounded theory study is an important step in the research process. First, I explain how rigour is conceptualized in grounded theory and then describe the methods used in this study to ensure rigour.

Glaser and Strauss emphasize methodological rigour (Cooney, 2011) whereas other grounded theorists such as Charmaz (2010) emphasize the importance of interpretive rigour. Methodological rigour relates to how closely investigators adhere to techniques and/or methods used in the particular research process. Whereas, interpretive rigour “emphasizes the trustworthiness of the interpretation made…attention is paid to the analytic process, how researchers draw their conclusions and the extent to which conclusions are grounded in the data” (Cooney, 2011, p.18). In addition, some researchers (Corbin & Strauss, 2008 as cited in Cooney, 2011; Elliott & Lazenbatt, 2005; Sandelowski, 1993b; Whittemore, Chase & Mandle, 2001) suggest investigators consider both adherence to methodology and interpretation of findings in their results in order to ensure rigour in the study.

Corbin and Strauss (2015) and Charmaz (2010) report that researchers need to balance scientific measures of rigour and subjectivity with creativity. Both authors suggest that researchers consider following measures of rigour such as credibility, originality, resonance, and usefulness in their studies. Whereas, other researchers such as Chiovitti and Piran (2003) and Cutcliffe (2005) suggest that investigators use the following standards of credibility, auditability, and fittingness to ensure rigour in qualitative studies.
In addition, certain methods used in grounded theory studies such as constant comparison and theoretical sampling further ensure methodological rigour in the study’s results.

In this study, I considered the above-mentioned measures mentioned by all the authors and found certain measures such as originality difficult to establish early in the research process. In grounded theory studies, investigators begin the research process with only a broad understanding of the problem; therefore I was unable to ascertain originality at the outset of this study.

In this study I considered criteria for both, methodological and interpretive rigour and found that the following three criteria were suitable to establish rigor in this study. They are credibility, transferability, and auditability; I describe each and provide examples of how each was used to ensure rigour in this study.

3.7.1. Credibility.

A study is found credible by “providing vivid and faithful description that [the] individual who had the experience could recognize it as their own” (Cooney, 2011, p. 19) and relates to the trustworthiness of the study’s results. Credibility means how accurately the theory explains the situation (Chiovitti & Piran, 2003; Cooney, 2011; Cutliffe, 2005; Sandelowski, 1993b; Whittemore, Chase & Mandle, 2001).

In this study, I utilized four strategies to establish credibility. They were concurrent data collection, checking emerging categories against data, use of participants’ actual words and reflexivity (Cooney, 2011; Chiovitti & Piran, 2003; Cutliffe, 2000). In relation to the first two strategies, I collected data from each participant and analyzed the data concurrently. For instance, when the category building relationships emerged from the data, I developed new interview guide with this category in mind so as to delve more deeply into this issue with subsequent participants. Additionally, I checked each participant’s responses against emerging themes. Also, I included participants’ insights and thoughts and made changes to forthcoming interview guides to show how participants guided the inquiry. I provided participants actual words in building the main concepts in the theory. For instance, participants mentioned words such as partnership which emerged as one of the main concepts in this study.

Reflexivity is an analytic measure used by researchers using grounded theory that employs particular strategies. Memoing is one strategy that investigators employ to ensure reflexivity (Cutcliffe, 2000; Hall & Callery, 2001; Mills, et al., 2006a; Neill, 2006). For instance,
I made notes in a separate column about my thoughts, ideas and feelings during the interviews with participants. Also, I taped recorded my thoughts immediately post interview and transcribed them verbatim. Later on and on re-reading participants’ interviews, I again noted my thoughts and impression in a separate column. In the “Discussion” section of this thesis, I explicitly separate my thoughts and impressions from that of the participants.

Additionally, in the “Introduction” section of this thesis, I explained my reasons for examining this problem. Also, I outlined my lens, a critical pedagogical lens that I used to examine the data and in doing so made explicit my perspective in this analysis. In using a constructivist approach forwarded by Charmaz (2010), I have made explicit my voice in rendering this thesis. Using a constructivist approach, researchers as “co-constructivist” can include his or her own voice in order to present (themselves) as a human being and not a disembodied data gatherer” (Mills, et al, 2006a. p. 11).

3.7.2. Transferability.

Transferability is also known as fittingness (Cooney, 2011) and is the second measure used in this study to ensure rigor. A study meets this criterion “when [the] audience views its findings as meaningful and applicable in terms of their own experience’ (Sandelowski, 1986 as cited in Cooney, 2011, p. 21). One measure to ensure transferability is to provide contextual data such as demographics information about participants and their characteristics. For instance, in the “Methods”, “Results” and “Discussion” chapters of this thesis, I provide detailed descriptions about participants’, their teaching contexts and their experiences while teaching in the clinical arena.

Also, investigators by providing thick and rich descriptions from the data enable readers to make decisions regarding transferability of findings (Creswell, 2007). For instance, I transcribed the participants’ experiences verbatim and provided the same in the “Results” and “Discussion” chapters in this thesis. In providing thick description, readers can make reasonable inferences as they transfer the information to other settings. In addition, investigators by providing readers with detailed description of participants’ experiences enables readers to ensure transferability of study findings to other contexts (Cooney, 2011).

Another measure to ensure transferability is to discuss similarities between study results and theoretical constructs in the literature (Chiovitti & Piran, 2003). In the “Discussion” chapters
of this thesis, I situate important concepts that emerged from the data such as *ethics in teaching* with concepts located in education literature.

**3.7.3. Auditability.**

Auditability refers to the ability of subsequent researchers to follow methods used by the original investigator and to draw similar conclusions of the original author (Chiovitti & Piran, 2003). I used three methods to ensure auditability: verification of transcripts by participants, selection of participants and memoing.

All interviews were transcribed verbatim and within forty-eight hours. Transcriptions were checked with audio interviews immediately and thereafter periodically to assess accuracy in the transcriptions of the data. Additionally, I sent four participants their transcripts immediately after transcribing their interviews to ensure accuracy in transcribing their thoughts and ideas. All four participants responded positively and did not add any further comments or additions to their transcripts.

Another strategy to ensure auditability in a study relates to the transparent process in the selection of participants (Chiovitte & Piran, 2003). I used three strategies in the selection of participants in this study. The strategies were purposeful sampling, criterion sampling and maximum variation to recruit participants in this study and I described each approach in detail in the methods section in this chapter.

Memoing is a method used in grounded theory to ensure that researchers keep a separate account of their ideas, thoughts, and interpretations throughout the process. Memoing is an analytic technique used by researchers to demonstrate validity in their study (Whittemore et al., 2001). During each interview, I wrote my thoughts, impressions, and questions in a separate column. I used memos as a separate and additional source of data. I detailed my memoing activities earlier and therefore ask the reader to refer to earlier section in this chapter.

**3.8. Limitations of the Study**

The main limitations of this study relate to data collection methods. In this study, I used interviews as the main data source as I was unable to observe participants teaching in the clinical arena due to organizational and situational constraints. Observing participants in their actual teaching practice would allow nurse researchers to gain a more in-depth and comprehensive understanding of the complexity involved in teaching in the clinical arena.
Early in this study design process, I contemplated asking participants to journal two important events from their teaching practice. I carefully considered the number of participants that would be willing to journal, the type of journal entries and how the quality of journaling would affect analysis of such entries. I realized that most clinical nurse educators work in a number of clinical areas and would be unable to spend adequate time journaling important events from their teaching experiences that influenced their teaching practice. Therefore, I decided against this source of data.

Summary of Chapter

In this chapter, I discussed the main assumptions that underpin grounded theory methodology and then described some important similarities and differences between the original approach to grounded theory as described by Glaser and Strauss (2005) and subsequent approaches. Also, I explained and justified my reasons for using a grounded theory approach forwarded by Charmaz (2010). I described the process for recruiting and selecting participants in this study and in the following chapter, I describe some important characteristics of the participants that emerged from the data.
Chapter 4.0. Study Participants

Overview of Chapter
In the previous chapter, I described the methods used to recruit and select participants for this study. In this chapter, I describe in detail some important characteristics about this group of participants that emerged from the data. First, I describe some similarities amongst all the participants before describing some important differences. I have provided aggregate data of the participants in order to ensure anonymity and protect the confidentiality of the participants.

4.1. Commonality amongst Participants

Twelve clinical nurse educators participated in the study. All twelve participants taught in undergraduate nursing students in both adult and paediatric settings that included acute, long-term, and community care. These settings reflect the current variety of locations in which clinical nurse educators’ work in undergraduate nursing programs. I first describe the demographic information of the participants that relates to the following categories: education qualifications, employment status, and type of nursing program.

The similarities that emerged amongst all twelve participants were the following: (1) All participants had obtained graduate degrees. Four participants had received graduate degrees, four in education and eight participants had received graduate degrees in nursing. The educational qualifications of participants reflect the required qualifications of current clinical nurse educators hired in undergraduate nursing programs. These eight participants had learned how to teach mostly through trial and error, and needed more probing in order to elicit reflective information about their teaching practice and interventions. (2) All but one of the twelve participants were hired on a part-time or contract sessional basis; (3) Eleven participants taught throughout the academic year; one taught part of the time in the winter term only; and some also taught throughout the calendar year. (4) Eight participants taught in two to three different schools of nursing, in Toronto, Canada, while the remaining four taught in one school of nursing. The employment experiences of these participants reflect the current employment situation of clinical nurse educators hired to teach in undergraduate nursing programs. Using grounded theory approach forwarded by Charmaz (2010), this diverse and varied teaching experience of participants allowed me to delve more deeply into a number of significant pedagogical issues and contexts, which informed the central concept of this study. Additionally, some participants were assigned an eight-hour clinical rotation while most were assigned a twelve-hour rotation,
depending on the nursing program in each school. In the table below, I have provided more detailed demographic information about the teaching experiences of all the participants.

**Table A. Demographic Information of Participants**

<table>
<thead>
<tr>
<th>Generic name identifier</th>
<th>Years in nursing</th>
<th>Years of teaching in nursing</th>
<th>Education qualifications</th>
<th>Type of nursing program\ The year in program that the participant is teaching\ Teaching in 1 or more schools of nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicky</td>
<td>Over 30yrs</td>
<td>14yrs</td>
<td>BSCN in community studies. MSCN and NP in family.</td>
<td>BSCN program\YR 1 and YR 2 Teaches in classroom and clinical arena. Taught in 1 school of nursing.</td>
</tr>
<tr>
<td>Sally</td>
<td>30yrs</td>
<td>8yrs.</td>
<td>Rn Diploma BSCN. Masters in Nursing (thesis).</td>
<td>BSCN program and 2nd entry program. YR 2 students. Taught in 1 school and 2 nursing programs.</td>
</tr>
<tr>
<td>Jessie</td>
<td>20yrs in Canada and international nursing experience.</td>
<td>10yrs.</td>
<td>BSCN, Masters in nursing with Education focus.</td>
<td>BSCN program. YR2 and Yr. 3 students Taught 2 schools of nursing and 2 nursing programs.</td>
</tr>
<tr>
<td>Adele</td>
<td>15yrs.</td>
<td>10 yrs.</td>
<td>BSCN. Masters in Nursing. Certificates in Adult Education Post graduate certificates.</td>
<td>BSCN program and 2nd entry program. YR 2 students. Taught in 3 schools of nursing and 2 nursing programs.</td>
</tr>
<tr>
<td>Keisha</td>
<td>20 yrs.</td>
<td>12 yrs.</td>
<td>BSCN and Masters in nursing CNA speciality certification.</td>
<td>BSCN program and 2nd entry program. YR 2 students. Taught in 2 schools of nursing and 2 nursing program.</td>
</tr>
<tr>
<td>Savannah</td>
<td>20 yrs. and international experience</td>
<td>7</td>
<td>BSCN MN with education focus</td>
<td>BSCN and 2nd entry program. Yr. 2 students. Taught in 3 schools of nursing and 2 nursing programs.</td>
</tr>
<tr>
<td>Name</td>
<td>Years</td>
<td>Program</td>
<td>Experience</td>
<td>Teaching Context</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>---------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Paris</td>
<td>30yrs.</td>
<td>BSCN</td>
<td>Master’s in Education.</td>
<td>BSCN and 2nd entry program. Yrs. 1, 2 and 3 students. Taught in 3 schools of nursing.</td>
</tr>
<tr>
<td>Althea</td>
<td>25yrs approx.</td>
<td>Diploma in Nursing. 1995-Integrated practicum of BSCN and NP.</td>
<td>BSCN program and 2nd entry program. Yr. 2 students Taught in 3 schools of nursing and 3 nursing programs.</td>
<td></td>
</tr>
<tr>
<td>Margaret</td>
<td>7yrs</td>
<td>BSCN Nursing</td>
<td>MN in Nursing</td>
<td>BSCN program. Yr. 2 students Taught in 3 schools of nursing and 2 nursing programs.</td>
</tr>
<tr>
<td>Jackson</td>
<td>10yrs.</td>
<td>BSCN in Biology. BSCN in accelerated Nursing program.</td>
<td>BSCN program. Yrs. 1 and 2 students. Taught in 1 school of nursing and 1 nursing program.</td>
<td></td>
</tr>
<tr>
<td>Karin</td>
<td>19 yrs. and international experience</td>
<td>BSCN Certification in maternity care</td>
<td>BSCN program and 2nd entry program. Yr. 2 students Taught in 1 school of nursing and 1 nursing program</td>
<td></td>
</tr>
<tr>
<td>Regina</td>
<td>16yrs</td>
<td>Diploma in nursing. BSCN in arts in health studies. BSCN in community nurse practitioner.</td>
<td>BSCN program. Yr. 2 students Taught in 1 school of nursing and 2 nursing programs</td>
<td></td>
</tr>
</tbody>
</table>

4.2. Important Difference in Teaching Contexts.

One important difference that emerged amongst participants relates to their teaching context. Some participants taught in collaborative undergraduate nursing programs while others taught in stand-alone undergraduate programs. Year 2 of an undergraduate nursing program relates to the students’ academic year in the program (relates to semester 3 and 4 in a four year undergraduate degree program or semester 1 and 2 in a 2nd entry program degree program).
Although all members taught in undergraduate nursing programs, five participants-Sally, Adele, Keisha, Savannah, and Paris—also taught in accelerated undergraduate nursing programs. Their insights make an important contribution to teaching nursing in the clinical arena in both undergraduate and accelerated undergraduate nursing programs—an aspect missing in nursing education literature. In addition, some participants taught in other non-degree nursing programs such as registered practical nursing and bridging programs and is noted by the number of nursing programs that the participant mentioned.

4.3. The Emergence of Two Groups of Participants.

During the interview process, I discovered some important differences in the experiences of participants. Identifying the variation in participants’ narratives shows the value of grounded theory methodology, as the researcher in using an interpretive lens can explore and present the multiple realities that emerge from the data and where facts and values may be inextricably linked (Charmaz, 2010). Group A consisted of eight participants (Nicky, Sally, Jessie, Adele, Keisha, Savannah, Paris and Althea), and Group B consisted of four participants (Margaret, Jackson, Karin, and Regina). In this section, I focus mainly on some important differences between these two groups as it relates to the education preparation of participants and their years of teaching experience and in the “Discussion” section I delve further into the implications of these differences in their teaching practice.

The teaching experience of Group A participants—Nicky, Sally, Jessie, Adele, Keisha, Savannah, Paris and Althea—in the clinical arena ranged from six to fourteen years. Also, these participants seemed to possess specific characteristics that complemented their teaching experiences and seemed more seasoned in their nursing and teaching experiences. Therefore I refer to this grouping of participants as “Seasoned” nurse educators. Also four participants in this group, Jessie, Adele, Savannah, and Paris had received graduate degrees in education.

The teaching experience of Group B participants—Margaret, Jackson, Karin, and Regina—ranged from three to nine years and I refer to this group of participants as “New” clinical nurse instructors.

I found four important differences between Group A (Seasoned) and Group B (New) participants as it relates to their relationship between nursing experience and their teaching practice; the relationship between their teaching experience and teaching practice; ability to
challenge the course leader, and self-identification as a nurse educator and discuss each in the following section.

4.3.1. **Relationship between nursing experience and teaching practice.**

The first difference that emerged relates to the participants’ nursing experience and its influence on their teaching practice. The nursing experience of participants in *Group A*—Nicky, Sally, Jessie, Adele, Keisha, Savannah, Paris, and Althea, ranged from fifteen to approximately thirty years. During the interviews, these participants needed minimal prompting and spoke enthusiastically about their reasons for using a nurturing approach in their teaching and described how their approach contributed to student learning.

By contrast *Group B* participants, Margaret and Jackson had seven to ten years of nursing experience respectively. Although Karin and Regina had approximately fifteen years of nursing experience, they had limited teaching experience and each taught in the clinical arena for eight and five years respectively. This group of participants focused more on meeting the objectives of the courses they were teaching than on their pedagogical practice.

4.3.2. **Relationship between teaching experience and teaching practice.**

Another difference that emerged relates to how participants with more versus less teaching experience provided different kinds of descriptions of their teaching. For example, seven of the eight participants in *Group A*—Nicky, Sally, Jessie, Adele, Keisha, Savannah, and Althea had taught in the clinical arena for seven to fourteen years. These participants provided thick descriptions of teaching in the clinical arena and the problems they encountered, and they detailed a number of recommendations that could improve teaching and learning in this setting.

Although Paris, the eight participant in this group had taught in the clinical arena for only six years, she was one of the four participants who had completed a graduate degree in education. This formal education may have enabled her to develop and articulate her teaching philosophy and guide her teaching practice more quickly than those participants who had taught for a similar length of time in the clinical arena but had not obtained graduate preparation in education. In addition, Paris shared many interesting insights about her observations across the three undergraduate nursing programs where she taught.

Whereas the four participants in *Group B*—Margaret, Jackson, Karin, and Regina had been teaching in the clinical arena for three to eight years and tended to focus more on course outcomes and instructional activities in describing their teaching practice.
4.3.3. Challenging authority.

A third difference that emerged between the two groups of participants pertains to each participant’s ability to question the decisions made by academic leaders in their departments. Group A participants, Nicky, Sally, Jessie, Adele, Keisha, Savannah, Althea and Paris tended to speak more candidly and confidently, detailing many experiences in which they challenged the academic lead’s decision, particularly if they felt that it compromised student learning. By contrast, participants in Group B with fewer years of experience in nursing and teaching seemed hesitant to raise questions or to challenge the authority of the course leader.

However, all participants recognized the risk of speaking up and challenging decisions made by academic leads because this could potentially result in a decision by the academic institution to not rehire them. The consequence of speaking up emerged as an important theme and is discussed more fully in the “Discussion” chapter.

4.3.4. Self-identity as nurse educators.

Another significant difference that emerged between the two groups of participants relates to both the speed and the nature of their self-identification as nurse educators. Four participants-Jessie, Adele, Savannah, and Paris—with graduate degrees in education seemed to transition well into the role of nurse educator. During the interview process, these participants referred to themselves as educators; provided detailed accounts and examples from their teaching experience; shared many insights on teaching in the clinical arena; and drew upon their teaching experiences to guide their practice in the clinical arena. I found that two factors aided in this transition process: having a background in education studies, and having at least six years in teaching and at least ten years in nursing. The transition process of becoming a nurse educator appears complex and requires in-depth, integrated knowledge and understanding of nursing, teaching, and learning.

4.4. Teaching in the Classroom and Teaching in the Clinical Arena

During the interview process, it became clear that one participant, Nicky, who taught in both the classroom and the clinical arena was able to offer particular insights into the similarities and differences of teaching in each environment. Her narratives denote another but important variation in experiences amongst the participants.

In the following narrative, Nicky indicates differences in terms of the level of responsibility of a clinical educator as opposed to that of a classroom teacher in nursing.
Teaching in the classroom in some ways is a party, it is a luxury. The responsibility is so much less. It is so completely different in terms of your accountability; it was brought home to me so clearly on the maternity floor where you have eight moms and eight babies, which is a lot of patients. I honestly don’t see how you can do that safely. You have 16 patients. Most moms and babies after birth are healthy and well but still you need to be on your toes (Nicky, 06-05-2014).

In the clinical arena, the clinical nurse educator has a dual focus of supporting students’ learning and ensuring that all students provide safe patient care. This dual focus adds to the responsibility of clinical nurse educators. This context differs in important ways from teaching in the classroom where the teacher’s sole focus is on student learning.

Nicky identifies another difference between teaching in the clinical arena and teaching in the classroom as it relates to building relationships with students. In the excerpt below, Nicky shares her feelings of loss about ceasing to teach in the clinical environment:

I am not teaching clinical next semester and I may never teach it again and I have started to grieve. I find that ...my strongest relationship is with my clinical students (Nicky, 12-06-2014).

Although Nicky clearly articulated the importance of building a respectful relationship with students in her teaching practice, the remaining eleven participants articulated similar sentiments. I delve more deeply into the importance of building a respectful relationship in the “Discussion” chapter.

Summary of chapter

In this section, I highlighted some important similarities and differences amongst participants. I detailed the emergence of two groups of participants, and named one group Seasoned and the other New clinical nurse educators based on important differences. I found that participants with graduate degrees in education, ten years of experience in nursing, and at least eight years of experience in teaching in the clinical arena were able to easily articulate their perspectives about their pedagogical practice and tended to focus more on creating innovative teaching methods. This is an important result as it enables nurse administrators to think more deeply about hiring seasoned nurse educators and in the planning of education sessions that meet the professional development needs of varied nurse educators.
Chapter 5.0. Theory Development and Results

Overview of Chapter

This chapter consists of three main sub-sections. In the first sub-section, I briefly explain the theory development process, the emergence of basic concepts and sub-concepts found in this study using grounded theory methodology and the conceptual framework. Concepts are derived from the data that represent the researcher`s interpretation of the meaning expressed in the words or actions of participants (Charmaz, 2010; Cutcliffe, 2005; Corbin and Strauss, 2015). In the second sub-section, I provide excerpts to explain each main and sub-concept. The excerpts include participants’ descriptions of their experiences, their insights of teaching in the clinical arena, my memos along with my interpretation of their teaching experiences. In the final sub-section in this chapter, I describe and explain the central core concept that emerged from the data.

5.0.1. Theory Development process

I briefly outline the emergence of descriptors, basic and advanced codes, sub-concepts and the main concepts in order to illustrate the development of a substantive theory in this study using grounded methodology. Strauss and Corbin explain theory in grounded methodology to mean ‘a set of relationships that offer a plausible explanation of the phenomenon under study’ (Goulding, 1998.pg. 52).

In the previous chapter, I described the use of analytic tools such as constant comparison and theoretical sampling used in this study in order to delve more deeply into emerging concepts, illuminate a concept, describe its properties or check for its relevance (Corbin and Strauss, 2015; Charmaz, 2010; Chen and Boore, 2009; Cutcliffe, 2000; Goulding, 1998). Here, I provide a brief explanation of how the use of one such analytic tool, theoretical sampling guided me in developing a sub-concept and how that contributed to a main concept found in this study. For instance, when a participant mentioned the Values that guided her teaching practice, I delved more deeply into how values guided the participant and each subsequent participant in their teaching. Also, by comparing new and emerging concepts, such as values across participants I was able to form early and preliminary conceptions of the data. Values emerged as an important element in the main concept, Ethics in teaching found in this study. Similarly, I analyzed all the data into basic and advanced codes (Corbin and Strauss, 2015), then conceptualised each code to form sub-concepts and main concepts.
In grounded theory, raw data is categorized and grouped as basic level concepts, whereas higher level concepts are more abstract (Corbin and Strauss, 2015; Cutcliffe, 2005). Concepts that share common characteristics are grouped under the same conceptual heading in order to organize, analyze and highlight key concepts. In this study, descriptors also known as basic codes such as observing, framing questions—were grouped together to form basic concepts. These basic concepts were then integrated to form sub-concepts that were further conceptualised to form main concepts. The purpose of refining and reconceptualising data enables researchers to move the analysis beyond the individual and/or particular context to describe and explain more broadly the phenomenon under examination (Charmaz, 2010; Cutcliffe, 2005). The main or theoretical concepts denote major themes, relate to other main concepts in the data and make the data meaningful (Charmaz, 1990; Corbin and Strauss, 2015). Five main concepts emerged from the data and form the study’s conceptual framework. In the diagram below, I have illustrated the important central, main and sub-concepts that emerged from the data. The five main concepts were further conceptualised to form the core central concept thus grounding a theory from the data.

5.0.1.1. Conceptual Framework in This Study

I introduce and explain the conceptual framework that underpins the study, and provide one excerpt to illustrate how I went about the analytic process.

Diagram of study’s conceptual framework

<table>
<thead>
<tr>
<th>Central concept</th>
<th>Main concepts</th>
<th>Sub-concepts that emerged from the data</th>
</tr>
</thead>
</table>
| **Pedagogical practices** | 5.1.1. Pedagogical knowledge | 5.1.1.1. Instructional Activities.  
5.1.1.2. Knowledge in Action  
5.1.1.3. Teaching milieu. |
| | 5.1.2. Building Pedagogical Partnerships | 5.1.2.1. Pedagogical partnerships with student nurses.  
5.1.2.2. Establishing professional boundaries with student nurses. |
| | 5.1.3. Ethics in teaching | 5.1.3.1. Personal/Professional values of clinical nurse educator participants.  
5.1.3.2. Balancing the learning needs of students with safe care.  
5.1.3.3. Teaching milieu. |
| | 5.1.4. Learning to Teach | 5.1.4.1. Knowledge of teaching  
5.1.4.2. Un-learning in order to teach. |
Navigating constraints found in complex education environments.

5.1.5. The Context

5.1.5.1. Challenges found in Curriculum and program.
5.1.5.2. Culture of teaching in nursing.

Central Concept: The pedagogical practices of clinical nurse educators and the navigation of constraints in complex educational institutions.

In a conceptual framework, each concept is layered, interconnected and multidirectional. Each concept is relevant to a central concept and provides a comprehensive understanding of the problem under investigation (Jabareen, 2009; Polit and Beck 2004). Basic concepts that share common properties and/or characteristics were grouped together and conceptualised to form sub concepts. In this study, basic concepts such as observing, instructing were grouped together to form one such sub-concept, Instructional activity. Sub concepts were then further conceptualised to form one of the five main concepts found in this study.

Each concept consists of properties and dimensions. A property is a characteristic or quality that defines and differentiates one concept from another. Dimensions provide a range within the concept and accounts for differences (Corbin and Strauss, 2015). For instance, the concept Building Partnerships includes a range of activities from that of providing support to students to the use of threat by clinical nurse educators.

I provide an example below of how I identified significant concepts in the data by using one excerpt from a participant who was instructing a student about the importance of aseptic wound care. I have used pseudonyms throughout this thesis to protect the anonymity of all the participants. Student nurses are first taught aseptic techniques in providing wound care in the classroom and are provided the opportunity to integrate their learning in the clinical arena. In the excerpt below, the participant’s instructional activities such as observing and asking questions are found. These two activities when grouped together with similar types of actions form a basic concept.

*With wound care, we teach the 2nd yr. students to clean your hands, take off the dressing, so the dirty gloves come off first, clean your hands again and put on new gloves. You don’t want to be using the gloves that you used to take the dirty dressing off to touch the clean supplies and apply the new dressing, it does not make sense. The same student, she is brilliant, good academically, had this wound dressing. She took everything off, cleaned the wound, when she took off the dirty dressing, the gloved touched the patients’ skin. I let her continue and let her do everything except apply the new dressing. I stopped her; the patient was older and sleeping. I said to her could you explain your rationale behind what you just did.*
And she said, I took off the dirty dressing, I cleaned the wound and put the new dressing on. I said but you touched the supplies with those dirty gloves, does it make sense to use same gloves with the new dressing which is going to touch the patients wound? She said she never thought about it. I guided her through the steps. For her it was eye opening experience and as she said to me that she really never thought about it (Margaret, 05-08-2014).

Margaret’s instructional activities were grouped together with similar such actions found in the data to form the basic-concepts. These basic concepts were then further conceptualised to form two sub-concepts, Instructional activity and Knowledge in action. These two sub-concepts shape the study’s first main concept, The Pedagogical knowledge of participants. In the same excerpt, the participant’s interaction with the student draws on principles of honesty and respect and illustrates the third main concept - Ethics of teaching - in this study. The same excerpt also illustrates the interconnection of three of the study’s main concepts, Pedagogical knowledge of participants, Building partnerships with students, and the Ethics of teaching.

In this study, five main concepts emerged from the data and each main concept incorporates two sub-concepts. Main concepts provide the structure or framework of a theory, carry analytic weight and propel the analysis forward (Charmaz, 2010; Cutcliffe, 2005). The five main concepts that emerged from the data are as follows.

Pedagogical knowledge of participants.
Building Pedagogical Partnerships.
Ethics in teaching.
Learning to teach and
The Context.

These five main concepts were further conceptualised to form the study’s central concept or central theory, The pedagogical practices of clinical nurse educators and the navigation of constraints in complex educational institutions and this concept is described in detail in the final section of this chapter.
Section 5.1- Study Results

In this section, I introduce and describe each of the five main concepts that emerged from the data and provide excerpts to illustrate the concept. Participants’ exact words were grouped together to form descriptors which were conceptualised to form sub-concepts and these sub-concepts were then further conceptualised to form main concepts thereby grounding the emerging theory in the data. The five main concepts were as follows:-

5.1.1. Pedagogical Knowledge of Participants
5.1.2. Building Pedagogical Partnerships.
5.1.3. Ethics in Teaching.
5.1.4. Learning to Teach and
5.1.5. The Context.

Next, I explain each concept in more depth and the corresponding sub concepts.

5.1.1. Pedagogical Knowledge of Participants

The first main concept that emerged from the data relates to the pedagogical knowledge of clinical nurse educator participants. The pedagogical knowledge consists of two sub-concepts, *Instructional activities* and *Knowledge in action*. First, I identify the descriptors that emerged from the data that relate to each concept and provide exemplars to illustrate the concept. At the end of this section, I provide excerpts to describe the teaching milieu in order to further situate the concept in the data.

5.1.1.1. Instructional Activities

The following basic concepts emerged that emerged from the results and were grouped together to illustrate this concept. They are:-

- Demonstrating skills; assigning students to patients; guiding, instructing, observing; framing questions; assessing patients; assessing students knowledge and application of their knowledge; providing students with appropriate learning opportunities; organizing/ lesson planning/ planning a clinical day; prioritization and juggling amongst students and activities; implementing teaching interventions; providing feedback/evaluating assignments; facilitating communication with team members.

The above mentioned activities were mentioned by all study participants. Each participant engaged in each of the above-mentioned instructional activities in varying degrees depending on
their clinical context, students’ knowledge and abilities. For instance, some participants provided more hands on demonstration while others instructed students in performing a procedure.

I discuss two of the above-mentioned descriptors—Assigning students to patients and instructing students. Clinical nurse educators’ engage in both activities on an ongoing basis and therefore an important activity to examine.

5.1.1.1. Assigning students to patients

Each participant reported engaging in this activity on a daily basis. I provide two excerpts to illustrate this descriptor as each participant utilised a slightly different approach. In the first excerpt, Jackson explains his process of making a student’s assignment.

_I assign students based on complexity and match with student skills. I research information on the resident and it takes me 2 hours, charts, kardex per patient. Even if I am quick it takes me 2hrs. I go through the charts, as I don’t know them. The information that I want my students to know obviously I have to know as well. To review all eight resident charts. I go into each chart, each resident even if I am quick, it takes time._ (Jackson, 26-03-2014)

Jackson would review each patient’s information prior to assigning each of his eight students to a patient. At times, Jackson would spend at least seven to eight hours in the nursing unit assessing all eight patients prior to determining each student’s assignment. Also, Jackson’s statement indicates the contextual elements that a clinical nurse educator should consider in order to make an appropriate student assignment such as, having an understanding of the patients’ condition, learning needs and clinical experiences of each student nurse in their group and pertinent information of the nursing unit.

Another participant Adele describes her decision making process of making students assignments in a long term care setting. The context such as patient’s medical condition and student prior knowledge of patients on the unit influence the participant’s decision making process.

_In long term care where patients stay for many days, on the 1st day in weeks 4-5, I ask the student to review their charts and find the patient they are interested in. Once they find a patient, they need to be able to justify their learning to me. I do this every week and every 2nd day of clinical they have to come and inform me._ (Adele. 11-08-2014)

Adele assists each student in their learning by encouraging each student to identify their learning needs. In doing so, Adele reveals her understanding of each student’s learning needs and abilities in providing patient care. Also, the excerpt reveals Adele’s acknowledgement of the
variations in the learning needs of students. In a latter conversation, Adele described how she
guides students’ learning by balancing their learning of psychomotor skills with integrating
knowledge and developing their cognitive abilities through their practice.

In comparing both excerpts, Adele adopted a different decision making approach than
Jackson in making decisions related to assigning students. It appears that Adele’s graduate
studies in education and ten years teaching experience may have influenced her pedagogical
approach. Important differences emerged in participants’ knowledge of teaching and in their
teaching practice. I have described some of the main differences amongst participants in the
“Methods” chapter and consider its implications in the “Discussion” chapter of this thesis.

5.1.1.2. Instructing students

The following scenario relates to student nurses and medication administration. The
participant assesses the students’ knowledge of the medication and patient’s condition and finds
important limitations.

We talked about the same meds day after day—Lasix, beta-blockers, everyday ay
she would forget to tell me the patient heart rate, or monitor the heart rate, or the reason the
patient was on a drug. The next day she would still not know. The next week we had to review it
again. I sat with her and told her you need to know this. I said tell me how you learn it. Tell me
what system work for you. (Karin. 05-05-2014)

In the above scenario, Karin hoped to understand how best to guide the student in her
learning about the action of medication’s and linking it with the patient’s condition. The scenario
uncovers Karin’s thought process guiding her assessment of the student and teaching
interventions.

Also, this scenario illustrates Karin’s contribution to student learning and reveals her
reasoning in balancing the student’s learning with her consideration about the student’s ability to
safely administer medications to a patient. The issue of balancing student learning with students’
ability to provide safe care is a recurrent theme and will be described in more detail later in this
chapter in the section—Ethics in teaching.

All three scenarios show the decision making processes of clinical nurse educator
participants and are a recurrent theme throughout the data. Participants engaged in making
decisions on a continuous basis. Participants were aware of each student’s knowledge, abilities
and areas of improvement. Also, they considered the severity of the patient’s medical condition
prior to assigning each student to a particular case—all in a timely manner.
Also, participants mentioned how the complexity of patients’ medical conditions has increased over the past few years while during the same time period, patients’ length of stay in hospitals has decreased. Together, these changes increased the frequency that participants had to assess and re-assess patient and student needs.

Clinical nurse educators need to possess in-depth and current knowledge of nursing practice and teaching in order to be able to accurately assess both student and patient, make appropriate decisions, plan and organize their time efficiently and spend time with each student so that that each student has the opportunity to learn, practice and integrate new knowledge in the clinical arena.

5.1.1.2. Clinical Nurse Educators and Knowledge in Action

Knowledge in action of clinical nurse educator participants is the second sub-concept under the main concept of **Pedagogical knowledge of participants**. In this sub-section, I first identify descriptors related to this concept; provide three exemplars to illustrate the concept before connecting this concept to the broader literature on tacit knowledge of teachers.

The tacit pedagogical knowledge of teachers is revealed in the teaching practices of educators. One participant described this form of pedagogical knowledge as follows.

*You develop this sixth sense which students need help. I did not have it in the beginning.* (Nicky, 06-05-2014)

In this study the tacit knowledge of the participants was revealed in the following contexts such as:-

- assessment, pathophysiology, ethical nursing care in practice; observing, developing students’ problem solving\critical thinking skills\ decision-making skills; developing students’ organization\ prioritization skills; developing students’ leadership\ advocacy skills; filling gaps in the curriculum; developing students’ accountability; and creating knowledge of teaching.

In the three exemplars below, Althea, Jessie and Savannah reveal their tacit knowledge of teaching in recognizing a learning opportunity, integrating their knowledge of nursing and teaching and tailoring their teaching interventions to guide the students.

5.1.1.2.1. Integrating concepts related to assessment

In the first excerpt, Althea recognizes a teaching opportunity and uses her situated knowledge of teaching in guiding the student to integrate the nursing process.
In my teaching I am looking for the nursing process. So you have five fingers (holds up her five fingers) which are going to be the nursing process. This is your assessment data (indicates first finger), your nursing diagnosis (indicates second finger), your nursing outcomes, planning, implementation and evaluation. Based on what I see you do, based on your report, I think and decide. Do you give me data only and ask me to intervene and tell you what to do. (Althea. 16-06-2014)

In the above exemplar, Althea assesses the student’s knowledge and integration of the nursing process framework in her practice. In doing so, Althea guides the student to move from assessment phase to planning an appropriate nursing intervention thereby enabling the student in the use of the nursing process framework in her nursing care.

In certain instances, a student engages in the assessment aspect of the nursing process only, while another student during the same time period might have been able to integrate three to four phases of the nursing process. Althea is aware of each student’s developing levels of knowledge, their ability to make a nursing decision related to patient care and each student’s progress in the course. Her detailed assessment and knowledge of each student guides her teaching. Althea’s knowledge of each student enables her in guiding each student to move from using a simpler early assessment phase to the more complex evaluation phase of the nursing framework.

Althea has been teaching in the clinical arena for nine years and stated that she developed her knowledge of teaching over time by observing students, seeking their feedback and reflecting on her actions. Over time this reflection enabled her to become more aware and recognize just-in-time teaching and learning opportunities.

5.1.1.2.2 Integrating ethical concepts in nursing practice

In the next excerpt, the participant reveals her situated knowledge of teaching as she guides the student in uncovering the ethical issues present in the nursing situation.

I had another student, and it was a surprise to her to see mom bottle feeding. She’s right, on the benefits of breast feeding. She could not understand why they were bottle feeding. I agreed with her 100% but I said we have to look at their (parents) decision. Whether we agree with it or not, and she was very surprised about it. I didn’t disagree that breastfeeding was not encouraged as she thought it should have been by the staff members. What I did is try and let her reflect on herself. It’s thinking about their thoughts, their understanding, their position, beliefs about what they could do differently. In this particular situation when I asked what your role is, maybe the mom might not be educated. She (sic-student) said she was because I read the benefits of breast-feeding with her. So I said she (sic-mother) made a choice to bottle feed her baby. As you have just mentioned she does know, but it was her decision. As difficult as it was for
everybody, I said it was very good of you as your role was to educate and to accept the mother’s decision although you did not agree with her in bottle-feeding her baby. (Jessie, 23-06-2014)

In the scenario, Jessie guides the student in becoming aware of the ethical issues inherent in the case and assists the student in making an ethical decision using professional standards. Jessie’s knowledge of teaching and nursing enabled her to recognize the learning opportunities in the situation and guide her actions. Also, her personal and professional values also informed and guided her teaching actions.

A few other participants also reported similar experiences and illustrate the diversity and complexity of issues that clinical nurse educators encounter while teaching student nurses in the clinical arena.

5.1.1.2.3. Guiding students in providing safe care

In the third scenario, Savannah realises that the student has yet to discover a potential medication error. In recognizing and intervening appropriately Savannah displays integration of teaching and nursing knowledge in the clinical arena.

I am checking the medications with her, and she said patient refused. I am looking at the MAR and thinking to myself why is the patient refusing her nitroderm patch. She (sic-student) said well it is a nitroglycerine patch. I asked why the patient has refused. She said the patient refused the day before and my nurse told me to write refused. I am thinking why? In her hand she held a nicotine patch. The nurse who transcribed the order wrote nitroderm patch and is should have been nicotine patch, she wrote the wrong patch. I said to her go bring the chart, this is not right. On checking the order, the doctor’s order is nicotine patch 21mg. and everyone wrote she refused. I said to her (sic-student) what we are going to do? We are going to the patient to find out why she is refusing. We did that. I explored with the patient and patient said she needs a cigarette when she goes to the toilet but is not addicted to smoking. Patient has a right to refuse. We go back to the MAR. You discovered an error, so what are you going to do? As you discovered the error, you have to change it, you have to stop it, re-write the MAR. You need to stop the error from continuing. (Savannah, 15-03-2014)

Savannah guided the student in recognizing a potential medication error and the steps required to correct the error from reoccuring. In doing so, Savannah guides the students in thinking more deeply about her nursing practice and become comfortable in raising questions related to patient care. Savannah recognized that this student was unaware of the significance of this error and in eliciting that awareness displays her tacit knowledge of teaching. Savannah has been teaching in the clinical arena for approximately seven years and both her nursing experience and formal graduate studies in education enabled her to recognize a learning opportunity and guided her teaching actions.
All participants carefully considered the learning needs of students, ensuring students were given the opportunity to meet their learning objectives and at the same time recognized the implications of their decisions on both student learning and patient safety. Balancing different and sometime oppositional needs requires careful deliberation by participants in the midst of the busyness found in nursing units. Also, each factor adds to the complexity of teaching of nursing and making decisions in the clinical arena. Participants recognized the ongoing need to frequently consider and weigh the learning needs of students with the student’s ability to provide nursing care in a safe manner. Some participants stated that the College of Nurses mandate (CNO), which is the regulatory body in Ontario, guided their decision-making while other participants stated that their ethical commitment to providing safe care to patients was for them, the main priority in guiding their decision-making.

Participants’ ability to recognize teaching-learning opportunities and respond appropriately in a timely manner seemed to be influenced by a number of factors including educational preparation, teaching and nursing experiences as well as personal values and beliefs. On examining the transcripts I found that some participants revealed their tacit knowledge of teaching more frequently than others. I found participants with more than seven years teaching experience (Nicky, Althea, Jessie, Savannah, Sally, Jessie, Adele and Keisha) were both, aware of, and revealed their tacit knowledge of teaching more frequently, particularly when discussing the development of students’ critical thinking skills, problem solving and/or decision-making skills. By contrast, participants with three to six years of teaching experience (Margaret, Jackson and Regina) were still in the early phases of developing their tacit knowledge of teaching and disclosed this form of knowledge mostly when discussing how and why they integrated subject content in their teaching. Although Paris had been teaching in the clinical arena for approximately six years, it seems her preparation in education studies seemed to enable her to disclose her tacit knowledge in developing students’ cognitive skills.

Interestingly, I found that even participants who had been teaching for over seven years continued to struggle in making such decisions. It appears that considering and weighing each variable within a limited time frame in complex nursing units’ remains a challenge for both seasoned and new clinical nurse educators alike.

I briefly explain the concept tacit knowledge as a form of pedagogical knowledge uncovered in the data. The development and use of this concept is not described in the literature
on nursing education, but is an important concept in the teacher education literature so I have instead drawn on that literature to help conceptualize how participants utilized their tacit pedagogical knowledge to guide their teaching actions.

Tacit knowledge is also known as situated or pedagogical knowing (Fenstermacher, 1994) or pedagogical content knowledge (Shulman, 1998), and pertains to knowledge developed by teachers through performing their work. This form of knowledge is not always easily articulated by the practitioner. It is the knowledge that is embedded in teaching practices of a teacher and includes the ‘how’ and ‘why’ of one’s practice. While the concept of tacit knowledge is multifaceted and the phenomenon is elusive in nature (Elliott and Stemler, 2008; Evans, 2006; Gholami and Husu, 2010; Tirri, Husu and Kamsanen, 1999; Toom, 2012), it can generally be understood as consisting of three main features:

1. It is acquired without a lot of input from others and occurs as a result of the individual’s experience of teaching in a given context,
2. It is context specific and not easily articulated or communicated,
3. It is tied to a teacher’s goals that the individual finds effective in a given situation (Toom 2012).

The development of tacit knowledge is influenced by particular factors such as reflection, observation and engaging in learning, and these factors are later described in detail under the heading Learning to teach in this chapter.

5.1.1.3. Teaching milieu

In examining the data, certain factors emerged that seemed to distract participants from their instructional activities and in their development of their tacit knowledge of teaching. The four most common factors that emerged from the data were: - instructor-student ratio, length of time in the clinical arena, being assigned to different physical locations within the building and undervaluing participants’ knowledge of teaching. These factors added to the stress that participants experienced while teaching in the clinical arena. Although all four factors negatively impacted the instructional activities of participants, the last factor deeply affected participants’ ability in developing their knowledge of teaching. I provide one exemplar related to each of the above-mentioned factors.
5.1.1.3.1. Instructor-student ratio

Participants’ reported having eight students at all times and all study participants mentioned the number of students assigned to each instructor as problematic.

In the excerpt below, student nurses had received minimal prior clinical experience yet were placed in busy and complex clinical settings.

If you have seven-eight students who are we kidding? How do we know all the implications of all the laboratory work for all the patients, the transfer needs of all the patients, especially when they (patients) are going home at a drop of a hat? Especially in a maternal-child ward where you have sixteen total patients- moms and babies with eight students. My part-time colleagues tell me that if clinical starts on a Tuesday, they get to know on Monday or Tuesday. (Nicky, 06-05-2014)

Nicky had eight student nurses to teach in the clinical arena and identified her concerns related to the number of students, their lack of prior nursing experience and its negative impact on making appropriate student assignments. Nicky explained that in order to make appropriate student assignments, she needs to have a good understanding of the learning needs of each student, the nursing needs of each patient in order to make appropriate student and patient assignment for student learning to occur. Nicky expresses concern about not being able to instruct students appropriately and in a timely manner due to a variety of curricular and situational constraints.

Nicky was a more seasoned participant having taught for more than fourteen years. It seems that seasoned clinical nurse educators like Nicky also struggle in making appropriate students’ assignments and in ensuring that each student meets the prescribed learning objectives. Nicky also mentioned the challenge and problems with clinical nurse educators not being given adequate preparation time for their particular students. Nicky seemed so preoccupied in ensuring that student nurses were able to provide safe care to patients, that she did not have time to reflect on her instructional interventions or her teaching while in the clinical arena.

Participants Jessie and Karin instructed students in a pediatric setting. Both participants mentioned similar concerns pertaining to the instructor-student ratio and its impact on their teaching. Additionally, all participants reported the instructor-student ratio as one of the main challenges in their teaching. The instructor-student ratio is chiefly determined by the number of students enrolled in the course. The data also revealed that both new and seasoned clinical instructors are given the same number of students regardless of their knowledge of teaching or prior teaching experiences.
5.1.1.3.2. Length of shift time in the clinical arena

Another factor that emerged as having a negative impact on participants’ instructional activities was the length of the clinical shifts student nurses are required to participate in. In the excerpt below, student nurses were placed on a unit for a twelve-hour shift.

_Currently I am doing a twelve-hour shift. I think this is wrong. By the end of 7\(\frac{1}{2}\) hours, your brain shuts down and slows down. You don’t want to be there anymore and begging for the next four hours. For the BSCN students, it’s the worst thing. These are young people who have never been in the workplace. It’s dangerous. It too long for them, it’s not just the twelve hour day. Currently my students come from far and by 3pm, they are dead tired and say we are tired, I cannot hardly keep up I am exhausted. So they don’t really learn._ (Savannah, 26-06-2014)

In the above scenario, Savannah had a group of eight student nurses and is responsible for instructing them in learning nursing skills, procedures and integrating concepts taught in the classroom during the entire shift. Savannah expressed concern about the length of a clinical shift and its negative effects on learning, instruction as well as the potential consequences for patients when student nurses spend twelve hours in the clinical setting. Savannah has been teaching in the clinical arena for seven years and acknowledges the harmful impact of prolonged exposure to extended shifts on her ability to concentrate and instruct students attentively throughout the shift. Additionally, three other participants’ also reported working with students on a twelve hour shift and raised similar concerns.

Teaching in complex and busy clinical environments over a long period of time coupled with meeting the education needs of all student nurses in a group is indeed challenging for most clinical nurse educators, new and seasoned alike. Also, clinical nurse educators need to be cognizant of their responsibilities to students and patients. The College of Nurses (CN0), the regulatory body for all nurses in the province of Ontario, states that the primary focus of nurse educators is to ensure that nursing students provide safe patient care (CNO, 2002; CNO 2009).

The excerpts reflect some of the challenges that clinical nurse educators encounter while teaching in the clinical arena. Currently, clinical nurse educators regardless of their knowledge or experience in teaching are assigned the same number of students and the same length of shifts in the clinical arena thereby adding to the stress of teaching in this context.

5.1.1.3.3. Wide distribution in location of students’ placement
The third factor that seemed to impede the instructional activities of the participants was due to students being placed in different physical locations within the building.

In the scenario below, student nurses with minimal prior knowledge were placed on different nursing units, in separate physical locations resulting in the participant having to spend more time travelling between the units.

*I often have student on different units in different areas and I run around keeping them organized and communicating with the nurse. In a typical day, it is very rare for me to get a bathroom\nutrition break. I am on the go for probably thirteen hours by the time I am completed.* (Sally. 16-05-2014)

Sally describes how, by having to spend more time travelling between students, she is unable to consistently instruct or guide nursing students thereby adding to her dilemma of ensuring that each student is engaged in their learning. Additionally, the student assignment process significantly interferes with her own well-being in not being able to take breaks during the long shifts.

Another participant, Regina, also reported similar challenges when she was placed on different types of nursing units and in different physical spaces within a hospital on a regular basis while trying to teach a widely dispersed group of students.

In both scenarios, participants appeared overwhelmed. The implication for these practices on instruction and student learning needs to be carefully considered as they significantly impact the overall quality of instruction and impact differently student learning experiences within the same course. Student nurses are placed in clinical settings based on pragmatic considerations, such as their proximity to a location rather than criteria based on their academic abilities or learning needs. Also, students are placed in a group based on the number of students enrolled in the course and not on the academic ability of each student. Similarly, clinical nurse educators themselves are placed in various clinical settings to meet the needs of the nursing programs and not for reasons related to the nurse educators’ ability to deliver the most effective learning experience. Clinical nurse educators need to learn the routines and protocols of many different clinical settings in order to guide their students to the particularities of the specific unit context. Also, the clinical expertise of nurse educators differs and each nurse educator may not be comfortable teaching in a general medical-surgical unit. The selection and placement of students and clinical nurse educators in the clinical arena remains problematic.

5.1.1.3.4. Undervaluing participants’ knowledge of teaching
I found this factor to be the most important and pervasive in constraining the development of tacit knowledge of participants. Sally reports that her knowledge of teaching student nurses on recapping needles in a safe manner in practice was not valued.

The fact that I was not allowed to teach the way I knew was safe, even if the people above me who had designed the course had never seen such a thing. So they were not open to changing based on something that I had discovered in practice. I was not valued for my experience. Students suffer because of that. I have to re-teach in the practice placement about something so simple how we could give a needle. (Sally. 16-05-2014)

In the excerpt above, Sally expresses her concern that the method taught in the laboratory on needle safety was not sufficiently comprehensive to prevent students from receiving a needle stick injury in clinical practice. Her knowledge derived from her teaching experience in clinical was not recognised or acknowledged. Sally a nurse for over thirty years, has been teaching in the same undergraduate nursing program and in the same school for over eight years. The devaluing of her knowledge had a negative impact on her as an individual, as well as affecting her teaching and her contribution to student learning. As a result of these experiences, Sally took a more cautious approach in her teaching and constantly reviewed her teaching instructions in light of the negative feedback from classroom faculty, even though that negative feedback was not directly concerned with the efficacy of needle safety itself. Sally questioned her teaching abilities, her ability to effectively instruct students even though her method caused less injury.

During the interview and on recalling specific events, Sally became visibly upset and during those times I provided support through silence. The quiet period enabled me to appreciate the significance of the event to Sally. Being sensitive to a participant’s experience enables researchers using grounded theory methodology to discern the meaning of the event and its consequences for the participant (Charmaz, 2010; Corbin and Strauss, 2015). I was able to consider questions and later explore the meaning of the event to the participant. I inquired about the significance of the events in her teaching practice and inquired about her reasons for continuing to teach nursing. Sally stated that her love of nursing and wanting to share her knowledge with students were her primary reasons to teach in the clinical arena. A similar sentiment was reiterated by every study participant.

This result sheds light on the knowledge that clinical nurse educator participants bring to their teaching practice and the challenges that participants encountered in their teaching practice. As explained in the literature review of this thesis, conceptualizing the knowledge that clinical
nurse educators bring to their teaching practice is absent in nursing education literature however, it is a focus of research and scholarship in teacher education, and I draw on that teacher education literature in the next chapter to further situate this concept.

5.1.2. Building Pedagogical Partnerships

Building partnerships with students is the second main concept that emerged from the data and describes another important feature of the pedagogical process of participants. The term process in grounded theory represents a responsive, dynamic response, and the action-interaction of participants (Corbin and Strauss, 2015) in their environment. Researchers on examining the process elements in the results are able to examine more closely the context and the factors that influence one’s response. This main concept includes two sub concepts Pedagogical partnership with students and Establishing Professional Boundaries.

5.1.2.1. Pedagogical partnership with student nurses

I introduce the first sub concept Pedagogical partnerships, identify descriptors related to the concept, and provide exemplars to illustrate the concept. The descriptors related to this sub concept are as follows:-

Role playing; role-modelling; building students’ confidence and competence in one’s nursing knowledge; Coaching\using narratives to teach; supporting and guiding students when they make mistakes\failing students; building partnership with students; using hope and encouragement; debriefing; sharing, dialogue and discussion, creating a safe learning environment; enabling peer collaboration\support. Using threats; fear and bullying students.

Participants mentioned these descriptors in varying degrees as they described how they built a pedagogical partnership with their students. All participants seemed to engage in building a partnership with their students on a regular and consistent basis and each participant expressed that building a relationship with students was one of the most rewarding aspects of teaching in the clinical arena. I provide three narratives to reflect its importance and focus on the following basic concepts: Role playing; role modelling; Building student’s competence and confidence; supporting and guiding students when they make mistakes.

5.1.2.1.1. Role playing; Role modelling

In the first scenario, Keisha found that one of her student’s was nervous and anxious about caring for a patient.
I role-play, we have little skits. I have the student by myself and I will tell the student, I am the patient and you are the nurse and we will role play. Here we go back to relationship, building, and a relationship with the student. From the time I realize that the student is timid I know I have to spend more time with the student. So I will take her aside and say let’s have a little skit. I know that you are nervous and scared so we role play. One time, the student is the patient and I am the student nurse and I show her how I would do it. Then we will reverse roles- making eye contact, a smile and wait for acknowledgement. She will then practice this with me. We will then go into the patient’s room together. (Kiesha. 02-06-2014)

Keisha details her teaching activities in promoting the student’s confidence by modelling the appropriate behavioural response. Kiesha provided a safe learning environment for the student to practice within and guided the student in becoming more comfortable and confident before approaching the patient. By doing so, Kiesha built a trusting relationship with the student.

5.1.2.1.2. Building student’s confidence and competence

In the following scenario, the participant found that the student was nervous in administering an injection, a procedure the student had performed a few times.

I do this by giving them the opportunity to practice by providing as much support as necessary, by giving them feedback. Not always necessarily positive feedback but constructive feedback. I had a student last semester that was terrified of giving injections and even though I saw her do eight injections and she was perfect every time, she was so afraid doing it on her own. I kept saying you are doing it absolutely perfect there is nothing more I can say to you but I will come with you. (Karin. 20-06-2014)

Karin’s calming and reassuring manner enabled her to build a supportive relationship with the student. Also, Karin’s words of encouragement helped the student in developing her confidence in performing the procedure.

5.1.2.1.3. Supporting and guiding students when errors occur

Clinical nurse educators encounter students with varying knowledge, skills and abilities. In the following scenario, Keisha encountered a student nurse who had not performed a thorough physical assessment and was in the midst of ambulating a patient with mobility problems. Keisha realised that the student was unaware that the patient was at risk for falling.

I was there when a student was trying to get a patient out of bed and the patient was going to fall. I always try to have the discussion, why were you doing this, why were you getting the patient out of bed by yourself and not calling one of your colleagues? I always try to find out their rationale. If they can answer with a rationale and see the big picture, they would not do that again. I always try to see what is going on in their minds. Let’s see what is going on in the course on fall prevention, we’ll have a discussion. I try not to be confrontational with them as they will get defensive. (Kiesha. 06-05-2014)
Kiesha had a conversation with the student about her assessment and rationale for ambulating the patient without seeking assistance from her peers. Keisha’s manner was respectful and factual. In reviewing the student assessment of the patient and the situation, Kiesha guided the student in learning the importance of performing a thorough physical assessment and making appropriate decisions related to safely moving a patient.

On examining the data, I found a number of instances where participants’ reported that students did not possess the required knowledge to make informed decisions about the care they provided. For instance, participants’ found that students had difficulty in assessing patients and intervening appropriately. It appears that students may have been exposed to that factual knowledge but were unable to apply their learning to the situation. Perhaps, the content itself and how the content was taught in the classroom contributed to student nurses lack of understanding and subsequent transfer of learning from the classroom to the clinical arena. The problems related to the development of this curriculum and how it was taught as described by the participants’ are detailed later in this chapter under the heading “The pedagogical context”.

All participants expressed the importance of building partnerships with their students in order to guide student learning. Building a pedagogical relationship with students takes knowledge, effort and care as a pedagogical relationship is not merely based on assistance, but assistance of a particular kind (Hansen, 1998); where the teacher places the intellectual and moral development of the student as essential to their teaching both in formal and informal ways (Hansen, 1998). The author adds that teaching has its own set of responsibilities and obligations that practitioners learn through preparation and practice. Participants in the above-mentioned scenarios demonstrated building pedagogical relationships with their students by assisting students in developing both their academic abilities and professional obligations as student nurses.

5.1.2.2. Establishing Professional Boundaries

This is the second sub concept of the main concept, Building Partnerships, and relates to participants’ responsibility as professionals. I detail the descriptors pertaining to this concept and provide one exemplar to illustrate the concept.

The basic concepts pertaining to this sub concept are as follows:

- Setting professional boundaries in student-teacher relationship; negotiating boundaries between personal and professional self.
5.1.2.2.1. Setting professional boundaries in student-teacher relationships

Teaching in the clinical arena seems complex, multifaceted and multilayered. Clinical nurse educators often work with students in confined spaces, over a prolonged period of time and this close proximity influences the teacher-student relationship; it also adds to the complexity of teaching in the clinical arena. Strong emotional interaction between and amongst student nurses, teachers and students adds to the complexity of this teaching.

In the following excerpt, Adele explains the amount of time it took her to learn about setting professional boundaries and the importance of setting those boundaries.

*It takes time and experience to be able to distinguish between yourself and your role. As I became more experienced I became more attuned. I had a student last semester, she was twenty years old. Her mother went back to (country) and the student said I am all by myself what am I going to do. She was treating me as her mother and I said you have to be able to detach yourself from me as I am not your family member. It was difficult for her but it was my professional responsibility that I cannot get engaged with the student. You feel sorry for the student. Every morning during clinical, she told me what she did last night, what she cooked. I said you need to stop. If you have questions related to clinical, please ask me. However if you have questions about your personal life, this is not the place. It not easy, it’s not easy. Students come in trusting you so much and you feel obligated to give back so much, and you can’t, you can’t. I like my students but I need to draw the line between liking the student and being a professional educator. I tell the student I like you as a person but as a nursing student this is what it is. (Adele. 11-08-2014)*

In the above scenario, Adele describes a situation when she had to separate her personal feelings from her responsibility as a clinical nurse educator. Adele stated that it took her some years in teaching before she was able to both establish boundaries in the teacher-student relationship and identify situations for potential boundary violations in that relationship. Adele stated that knowledge coupled with reflection and experience in teaching has enabled her to develop and maintain an ongoing professional relationship with students. Adele has taught in the clinical setting for ten years and drew on her teaching experiences and course work in education to help her maintain professional boundaries. Clinical nurse educators need to be able to set professional boundaries and separate the personal self from the professional role as the educator role has inherent legal responsibilities. Developing professional partnership and how to establish professional boundaries between nurse educators and students is absent in nurse education literature.

Stokes (2007) suggests that when students are faced with personal and/or academic problems they engage the nurse educator as a counselor. In the clinical arena, where clinical
educators work more closely with students there are at times a blurring of pedagogic boundaries in the face of student distress and the nurse educator’s desire to help (Ewashen & Lane, 2007). Setting professional boundaries in the teacher and student relationship requires knowledge, self-awareness, reflection, teaching experience and guidance. However, all participants reported incidents where they did not receive timely or adequate guidance related to their role or teaching in the clinical area. Participants also mentioned that they learned about setting professional boundaries on their own or in casual conversation with their peers. Formal or structured mentoring was not offered nor is it common practice in nursing education. A number of educators such as Boyd and Lawley (2009); Boyd, (2010); McKenna (2004); Fanutti (1993); Young (1999) and Young and Diekelmann (2002) mention the importance of mentoring for new and seasoned nurse educators particularly as most nurse educators tend to learn to teach on the job.

This result emphasizes the importance of building a meaning partnership with students in order to guide students in their learning. Although, building partnerships is not addressed in the literature in nursing education, the professional relationship and moral responsibilities of teachers is described more fully in the teacher education literature which again I draw on in the “Discussion” chapter of this thesis.

5.1.3. Ethics in Teaching

Ethics in teaching is a third main concept contributing to the central concept in this study and reveals the ethics that underpins the teaching practices of participants. This concept consists of two sub concepts- Personal and Professional values and Balancing students’ learning with safe patient care. First, I introduce and describe each sub-concept, the descriptors that emerged from the data and then provide excerpts to illustrate each concept. At the end of this section, I provide exemplars to describe the teaching milieu so as to further situate this concept in the results.

5.1.3.1. Personal and Professional values

Personal and professional values of participants emerged as an important concept. I provide descriptors that emerged from the data and two exemplars to illustrate its conceptualization in this study.
The descriptors pertaining to this sub concept include the participant’s personal values and beliefs, their beliefs about learning and teaching and the values that underpin their pedagogical stance. The descriptors found in the data are as follows:

Honesty, respect, openness, fairness; caring for the student; demonstrating caring for the patient/family; commitment to the profession and professional standards.

I provide three excerpts detailing the first two of these concepts, honesty, respect, openness and caring for the student. These excerpts highlight the personal values that inform the professional stance of the participants.

5.1.3.1.1. Honesty, respect, openness

In the first excerpt, Jackson shares his personal values that underpin his teaching practice.

Going back to elements for a good teacher- open to listening to the student and not just assuming that they are a blank slate and know diddly-squat. More so with our mature students going into the program now they come from a variety of backgrounds and have a lot of knowledge to share and that’s something we should recognize. Not everybody going into nursing now is seventeen and from high school. Even then they may have knowledge. Respect has to go both ways so I think it’s an important thing for a clinical instructor and not just make the assumption that you are a student and learning so you should listen to what I say. No, there needs to be a dialogue. If there is no dialogue then it makes poor learning experience for the student. (Jackson, 09-06-2014)

Jackson identifies the importance of personal values such as listening and respect in building a relationship with students in order to promote an environment conducive to learning. Jackson believes that each student comes with knowledge and experiences that he needs to draw upon in order for learning to occur. Although, Jackson had been teaching for only five years his approach to teaching seems to reflect ideas expressed by education scholars such as Dewey (1938\1997) and Pinar (1975, 2012), who value building upon students’ prior learning experiences in order for current learning to flourish. Both authors state that by building on students learning experiences, teachers are able to enhance student learning.

A few participants also mentioned similar values guiding their teaching practice. Participants’ seemed to adopt a more progressive and understanding approach in their teaching and this approach emerged as an important concept in the data.

5.1.3.1.2. Caring for the student
Many participants identified caring as an important value in building a pedagogical relationship with students and in modelling caring practices. Also, caring is an important value in nursing and I provide two excerpts to illustrate its importance to participants.

In the following exemplar, a participant shares her reason for caring for a nursing student.

*We are a whole person and not only a nurse. The student is a whole individual not just a nursing student. I love sharing my knowledge, mentoring the younger generation. It is important because they are the future nurses, for us and our families. They need strong nurse educators behind them.* (Keisha, 05-05-2014)

In this exemplar, Keisha indicates the importance of caring in her teaching practice. Keisha views the student holistically, and focuses on developing the whole person within their role as a student nurse. Keisha believes that separating the person from the student role does not benefit the individual or their learning as a student nurse-a similar sentiment expressed also by other participants.

**5.1.3.1.3. Caring for the student when an error occurs**

In the excerpt below, Savannah realises that a student has made an error and provides the student the opportunity to address the mishap from her\his perspective. Errors could be actual or potential, and are also known as ‘near misses’. The seriousness of the error depends on a number of factors including the type of error and consequences to the patient.

*If there is an error, mishap; I bring it into the clinical conference and we talk about it. The student has the opportunity to say this happened to me. If they don’t want to say anything, it is OK with me. Everyone learns from the experience. So next week they are aware and they are not going to make the same mistake. I treat all my students alike, I want them to progress. There is no way they will leave me and say this one is her favourite, she did not give me this or that learning opportunity. She gave her favourite student (sic-A) the experience and I did not get this experience. I cannot afford that.* (Savannah, 15-03-2014)

In the above excerpt, Savannah identifies her personal and professional values of honesty, fairness, and being open by including each student in the discussion and treating all students fairly when errors occur. The excerpt also details Savannah’s non-judgemental manner which is influenced by her personal and professional values that underpin her teaching practice.

While ethical values and ethical problems that nurses’ experience in practice are described in detail in the nursing literature, the ethics that underpin the teaching practices of nurse educators is not directly addressed in that literature. Therefore, I have drawn on the literature on the ethical practice of teachers and teacher educators to situate this important concept. In the educational literature on ethics of teaching, a teacher’s character is considered
central to her/his moral agency and an ethical teacher is seen as adopting and nurturing values that become an integral part of a teacher’s responses (Campbell, 2003; 2003a; 2008; Fenstermacher, 2009; Hansen, 1998; Smith, 1996). An ethical teacher demonstrates values of honesty, integrity, fairness, compassion in their teaching practices and in their interactions with students.

Teaching from this perspective is seen as a moral activity as the activity itself is saturated with moral significance (Hansen, 1998; Strom, 1989). Teaching includes guiding, instructing students, helping students articulate what they did not know. Hansen (1998) explains that practitioners do not ‘choose these responsibilities and obligations; they do not choose the moral dimensions of the endeavour. Rather they discover them through pondering and engaging in the work’ (p. 649). Effective teaching is premised on guiding and enabling students in their intellectual and moral development as individuals. Participants revealed the moral dimension of their teaching operating in their work through articulating the premises that undergird their teaching.

5.1.3.2. Balancing the Learning needs of Students with Safe Patient Care

This second concept further reveals the teaching context of participants. I provide descriptors related to this concept and provide one exemplar to illustrate the concept.

The descriptors pertaining to this sub concept are as follows: -

Instructing students in providing safe care; weighing the learning of students with safe patient care.

In the excerpt below, Karin encountered an ethical issue where she had to carefully consider the learning needs of the student and balance it with the student’s capacity to safely administer medications to the patient.

_**I had a student who wanted to give insulin. I want to give insulin, it was a 12hr shift, and I said OK you could give the 5 o’clock insulin. Great I can’t wait (sic-student states). At 430pm, I started asking him about insulin, what type of insulin it is, when do you expect it to peak, etc. etc. and he couldn’t answer any question. I said you are not prepared; giving insulin is more than stabbing a patient with a needle. You need to have the knowledge and you don’t. Try again tomorrow. (Karin. 20-06-2014)**_

In the above situation, Karin realised that the student was focused on performing the skill rather than considering the required knowledge needed to administer the medication safely to the patient. In assessing the student’s knowledge and recognizing the learning opportunities inherent
in the situation, Karin weighed the pros and cons of her decision. Karin considered the student’s learning needs in relation to the importance of safe patient outcomes in the learning context. Her values related to nursing and teaching guided her in requiring the student to possess in-depth knowledge of the medication before the student could be considered able to administer the medication safely.

Throughout the interviews, participants were keenly aware of their ethical responsibility to students and patients and their commitment to professional values and standards. All study participants mentioned frequently and detailed a number of experiences where they had to balance the learning needs of students’ with the student’s ability in providing safe care to patients. The College of Nurses of Ontario (CNO), states that ‘while planning the learning experience, the educator will place the safety and well-being of the client above all other objectives’ (CNO. 2009, p. 3). Some participants provided this standard as a guide in their decision making whereas other participants were guided by their personal values in addition to the standard. The results from this study also revealed that participants seemed to possess a deeper and more nuanced understanding of safe patient care than nurse educators developing the curriculum. This difference in understanding of safe patient care amongst nurse educators is a significant result and is further explained in the “Discussion” chapter.

Furthermore, in discussing the issue of student errors with participants it seemed that ethical issues that participants encountered were not addressed by the nursing programs. Also, participants did not feel they were provided with the opportunity to share their experiences or learn with other clinical nurse educators who had encountered similar experiences. Structuring learning opportunities for clinical instructors to share important information such as patient safety could be an important additional element in orientation programs for nurse educators and nurse administrators given the importance of safe patient care in undergraduate nursing education.

Overall, the transcripts seem to suggest that all nurse educators including clinical nurse instructors should be provided the opportunity to participate in sharing their teaching and learning experiences within a learning community so that the individual practitioner could benefit from this experience. In a learning community (Wenger, 2000) of nurse educators, individuals are provided the opportunity to share, discuss problems and bring solutions forward
that could benefit nurse educators and student nurses. I discuss the benefits of a learning community of nurse educators in more detail in the Recommendation chapter of this thesis.

5.1.3.3. Teaching Milieu

Some factors emerged that made teaching ethically difficult in the clinical arena and the two most common factors that surfaced relate to the high teacher-student ratio and the lack of inclusion of participant’s input into decisions related to the clinical curriculum. This latter issue was described by many participants and emerged as a significant problem; therefore I provide two excerpts to illustrate the problem. First, I provide an excerpt to illustrate the problem relating to the current teacher-student ratio.

5.1.3.3.1. Instructor-student ratio

In the first excerpt, Margaret identifies the teacher-student ratio as problematic as the teacher needs to carefully weigh the learning needs and abilities of each of the eight students against their current level of ability to provide safe care. Thus, this is not simply a problem of teaching overload, but an issue within the specific context in which teaching occurs.

*Having eight students is a lot. When you are starting to do medication and watch them do medication it is a lot. I think that’s the biggest disadvantage to clinical teaching compare to teaching in the classroom, I would say. You want to give each student a good chunk of your time and when you have eight students giving medications and all are due at 10am you really can’t. If 1 student takes half an hour, you have seven students who have to give meds by 10 am. I find this is the biggest challenge and huge disadvantage to clinical. In the other program I have five students, it is different as I can focus and spend a lot of time with 1 student in this program and focus my time and give that opportunity. As opposed to eight students it quite difficult and you are running especially if someone has meds round the clock. You don’t have time.* (Margaret. 27-06-2014)

Margaret had eight students in her group and some students were assigned to administer medications. She needed to ensure that each student possessed the required knowledge and abilities in order to administer the various medications safely to the patient. Additionally, as each patient has a number of medications, Margaret had to ensure that each student possessed in-depth knowledge of each medication so that she could administer the prescribed medications in a safe manner. Also, the short time frame to administer medication to each patient as determined by professional guidelines and unit policy was another source of stress expressed by participants. In addition, Margaret had to balance a number of competing teaching responsibilities amongst all eight students and those patients being cared for by each student.
Also, she had to consider a number of obligations; to students, patients and the profession, thereby adding to the complexity of ethical decision making in her teaching practice.

The data revealed that participants were engaged in making ethical decisions in their teaching on a regular basis and seemed to engage a number of interrelated roles simultaneously; teacher, caregiver to the patient, an educator to the student, the patient and the unit nurses thereby increasing the likelihood of encountering conflicting obligations.

5.1.3.3.2. Undervaluing participant’s input

I provide two excerpts to illustrate the significance of this problem. Also each excerpt describes a particular aspect of the problem thereby further situating the result in the data.

Excerpt 5.1.3.3.2.1

Keisha notes that her input into curricula decisions related to assigning students to patients in the clinical arena is not sought or considered in the decision.

_The curriculum states that students should have two patients by week six in the course outline. I should decide that. From the teacher’s perspective if she has eight students that means she has sixteen patients. That means monitoring all patients which I take seriously. My student’s patients are my patients. I think four students have two patients each one week and the other four students’ just one patient. The next week I would switch it. I find it stressful if all my students have two patients each._ (Keisha. 19-06-2014)

In the above scenario, Keisha mentions that the course syllabus determines when each student nurse is assigned to two patients each instead of the clinical instructor. This curricula decision seems to have caused Keisha stress and anxiety and she seemed overwhelmed and preoccupied in ensuring that each student learns to provide safe care to patients. A clinical nurse educator with eight student nurses needs to instruct eight students caring for about eight to a total of sixteen patients. While each student learns at different pace, the instructor is not allowed to make decisions that are adjusted for individual student learning. Also, such situations have a negative impact on the teacher’s ability in making good decisions as her time is spent instead trying to cope with the large amount of student plus patients, regardless of where individual students may actually be in terms of their level of knowledge and competence at that particular point in the course.

Keisha possessed the required knowledge, judgment and ability in assessing each student and determining the student’s ability to care for more than one patient at a time. Yet it seems that such decisions are determined by classroom faculty, some of whom may not be considering patient issues or aspects of student learning in the clinical arena. Additionally, Keisha describes
her frustration with dealing with nursing faculty who make decisions related to teaching in the clinical arena although they may not possess the relevant knowledge of clinical issues and contextual demands. Keisha has been teaching in the clinical arena for twelve years and although she has sound understanding of student learning in the clinical arena, her input into the course was ignored.

Nine participants in this study stated that they wanted more input into decisions pertaining to teaching in the clinical arena. One participant, Nicky worked full time and was therefore already part of the decision making process and the remaining two participants did not comment on this issue.

The scenario uncovers a divide between nurse educators, those who develop and set curriculum and those educators who are tasked to implement this curriculum. This divide is problematic. This significant division between classroom and clinical nurse educators seems to be based chiefly on classroom nurse educators having full-time employment whereas clinical nurse educators with graduate preparation but typically teach part time. There is less emphasis in either group, on pedagogical preparation. Although, a nurse researcher and nurse educator share complimentary knowledge and abilities; differences in status and power exist between nurse educators with a doctorate and nurse educators with graduate studies in education. The results from this study suggest that there should be a greater emphasis on knowledge of teaching, learning and educational research so that nurse educators learn to teach more effectively.

**Excerpt 5.1.3.3.2.2.**

In the following excerpt, Nicky realised that student nurses were required to administer medications early in their clinical rotation, before students had actually developed sufficient knowledge from their classroom experiences to fully inform their decisions in their clinical rotations.

I have colleagues who insist that students need to be giving medication right away and as soon as possible etc. I have worked very hard to stay true to what feel right to me in that regard. In fact, I did have a very serious near miss medication error. Thank goodness, we did not deliver the medication. It was insulin. It was one of the worst days of my life ever. It was six years ago but it seems like yesterday. As I have analysed that situation, I know because it was I felt a pressure from my colleagues to perform in a certain way and I was not true to my own certain beliefs about how to operate safely. I understand very much the need to help the students to deliver medications-all the skills-pre assessment, post assessment-knowing the indications, actions, interactions, side-effects. I get it. It is exactly because of all the complexity of that it is very very important to engage in a process that introduces them to that safely and slowly so that
I can with utmost confidence know that students are prepared to perform that skill. It seems to me that one the things that keep coming back is staying true to you own self- to stay true to the values that brought you to nursing. (Nicky, 12-06-2014)

Nicky alludes to feeling pressure from the curriculum and/or nursing colleagues to follow the prescribed curriculum. Nicky describes feeling torn between providing learning opportunities for students to practice their psychomotor skills even though they did not possess the required knowledge and judgment to administer medications safely. Nicky’s considers the options and makes a decision amongst competing obligations. Nicky explains how her values guided her in making this decision.

Medication administration is a complex learning activity for nursing students and unlike other procedures that undergraduate nursing students perform at this stage; medication administration is associated with high risk to patients. Errors in medication administration remain one of the most common errors made by nursing students (Balas, Scott, and Rogers, 2004; Erlen, 2001; Ketchum, Grass, & Padwojski, 2005; Patton, 2015; Reid-Searl, Moxham, Walker & Happell, 2010; Simonsen, Daehlin, Johansson, & Farup, 2014). Nicky identifies problems with both the curriculum and the concern that clinical educators input is often not sought and/or not included in curricula decisions related to teaching in the clinical arena. Overall it seems that neither the learner’s knowledge and abilities, nor the clinical educator assessment of the student, nor the ethical obligations of clinical instructors are acknowledged nor taken into consideration.

Although every participant mentioned the importance of ensuring that students provide safe care to patients, curricular decisions such as when students perform certain tasks or procedures are made by nursing faculty who teach chiefly in the classroom and do not necessarily work with students in the clinical arena. Also, nursing faculty teaching in the classroom may not be familiar with the constraints and challenges of teaching in the clinical setting or how students integrate curricula content in the clinical arena. The exclusion and/or dismissal of participant’s input in decisions related to the curriculum is particularly problematic because these participants are solely responsible for implementing the curriculum yet do not have any means to provide meaningful input into the curricular decision-making process. This lack of meaningful input in the curriculum is another source of stress reported by each participant in this study.
Emerging from these data are two distinct groups of nurse educators; the classroom faculty and the clinical nurse educator, each of whom have different levels of authority and influence in the development and implementation of curriculum. Clinical instructors bring significant knowledge to their teaching, yet this often seems not to be valued, and this situation is problematic. Some participants mentioned that faculty members (as opposed to clinical nurse instructors) did not have new or recent knowledge of nursing or teaching to support their recommendations yet their academic position within the nursing hierarchy largely meant that their recommendations were not questioned.

In analysing the excerpts using a critical pedagogical stance, it appears that only certain types of knowledge and certain types of bearers of that knowledge are considered valid in nursing education, and this raises a number of important questions. For example, who determines the types of knowledge that should be considered valid? What are the criteria used to determine the validity of this form of knowledge? and how does the authority of the individual in determining the validity of different types of knowledge factor into this process? Altogether, both excerpts underscore a divide of power and authority over knowledge claims between classroom nurse educators and clinical nurse educators. The divide reported by participants between themselves and classroom faculty is addressed in detail in the following section *The Context*.

Overall, I found that problems related to participants’ input not being considered reflect widespread practice as nine of the twelve participants taught in more than one school of nursing. Ten participants taught in more than one undergraduate nursing program, and some taught in both a traditional four-year degree program and an accelerated program. This issue seems more structural and systemic in nature and seems to permeate the culture of teaching in nursing education and is examined in more depth in the following section, *The Pedagogical context*.

This concept, *ethics in teaching* sheds light on the values that underpin the teaching practice of participants and some of the challenges that they encountered in their practice. The result also showcases the factors that influenced their teaching practice and how participants negotiated in maintaining professional boundaries while developing a pedagogical partnership with students. These are important results and their implications will be discussed in more detail in subsequent chapters.
5.1.4. Learning to teach

Learning to teach is the fourth main concept that undergirds the theory and is intertwined with the other main concepts. Learning to teach concept consists of two sub concepts: **Knowledge of teaching and Un-learning** in order to teach. First, I introduce each sub concept, identify the descriptors related to the concept, provide exemplars to illustrate the concept and briefly situate the concept in the broader literature.

5.1.4.1. Knowledge of Teaching

I first provide the descriptors that emerged from the data and then provide two excerpts to illustrate this concept. The descriptors that were grouped together to form this concept are:

- Current knowledge of nursing
- Formal knowledge of teaching
- Embodied nursing knowledge
- Reflection
- Experiential knowledge of teaching and nursing
- Learning to teach through trial and error
- Being open to learning
- Teachers as learners
- Observations
- Students’ feedback

Four of the twelve study participants, Jessie, Adele, Savannah and Paris received graduate degrees in education. The four participants explained how their studies in education guided them in their teaching practice, assisted them in choosing and developing appropriate teaching interventions and in determining in a timely manner how best to support their students. As such, this group provided an interesting comparison to the remaining eight participants whose academic preparation was solely in nursing, rather than education.

Each participant stated that clinical nurse educators should possess deep knowledge of nursing, current knowledge of nursing and nursing practice in order to teach nursing. I provide four exemplars to illustrate the following concepts- **embodied knowledge; reflection and reflective practice** as these were the most common forms of knowledge reported by participants.

5.1.4.1.1. Embodied knowledge of nursing

In the first excerpt, Savannah shares her views on the importance of having deep knowledge and expertise in nursing and stated that her embodied nursing knowledge and formal studies in education guided her in teaching.

> A catheterisation skill, I have the knowledge, skills, judgment as I know what I am looking for when I catheterise. I must also should have the art of caring. I should be able to talk to the patient, comfort the patient. Ask if they have scared of having a Foley- that’s the art of nursing. What the catheter does-it’s the knowledge piece. You have to marry the knowledge and art. (Savannah, 15-03-2014)
In this excerpt, it appears that Savannah’s deep knowledge of the science and art of nursing coupled with her knowledge of teaching together inform her teaching practices. Savannah has been teaching for over seven years and mentioned that she reflected on her teaching experiences on a regular basis and her formal studies in education as a way to develop her knowledge of teaching.

5.1.4.1.2 Embodied knowledge of nursing and teaching

In the following exemplar, the participant shared how using her deep knowledge of assessment of a newborn enabled her to guide students in listening to, and assessing, heart sounds in the newborn.

The assessment of a newborn is difficult such as assessing respiratory and heart rate. They would listen and time the breath sounds and then the baby would sneeze and they would lose their number. I would say that’s OK and start again. I would look at the couple and say it is difficult to assess any baby’s heart rate and not only their baby. They (sic-student) would tell me the respiration is 30. The lab is different from doing it on the real baby. So they need to count the respirations, I would say to them what is the normal respiration. They would say between 30-60. You have got 38 and it’s within the normal range. Very good. Tell the couple what you found. When we come out of the room I would say, very good, the positive reinforcement, makes a significant difference, it really does. (Jessie. 23-06-2014)

In this scenario, Jessie teaches students about accurately locating and listening to heart sounds and counting the respiratory rate of a baby. The scenario also highlights from the students’ perspective, differences in learning and understanding in a laboratory setting compared to the real experience of the clinical context. This is an important point for nurse educators to consider in planning the curriculum. Jessie’s knowledge and expertise as a paediatric nurse and teaching experiences guided her teaching. Also, Jessie’s enrolment in a graduate program in education coupled with her twenty years of nursing experience enabled her to determine when and how to assist students in their learning. Jessie’s embodied knowledge of teaching nursing seemed to guide her actions as she moved seamlessly from assessing students to guiding each student on how to count the baby’s respiratory rate.

Embodied knowledge is the experience of living in ‘and through the body’ (Draper, 2014. pg. 2236), knowledge gained through living in our bodies (Fenstermacher, 1994; Field & Latta, 2001; Wright & Brajtman, 2011). An engaged teacher first senses that students understand the material or not, and this feeling is primary and it acts as a trigger for the individual to search for meaning at a conceptual level. ‘Presencing’ is another form of embodied knowing (Estola &
The presence of the teacher includes how the teacher behaves, her/his gaze or smile, and the verbal and non-verbal messages the teacher sends to students. These are all entrenched in the daily activity of a teacher and represent intrinsic aspects of teaching. A number of participants mentioned the importance of being aware of their non-verbal cues. Keisha mentioned:

*With one of my students I had to stand with her, she wrote what she was going to say to the doctor. I was right there when she called and spoke with the doctor. I said you can do it, you can do it. She read from her paper and spoke with the doctor. (Keisha, 06-19-2014)*

In this excerpt, Keisha’s physical presence and instructions guided the student speaking with the physician.

In these results, most participants seemed to possess deep understanding of nursing that enabled each participant to teach students effectively. I found that those participants with more than fifteen years nursing experience and at least seven years’ experience in teaching were able to provide in-depth, varied and rich descriptions of how their embodied knowledge of nursing enabled their teaching. These participants were able to marry the art with the science and teach consistently and seamlessly in their practice. By contrast, participants with only seven years of nursing experience and three to five years of experience in teaching seemed to focus more on the delivery of content than on the nuances of their teaching practice.

This result is similar to the conclusions reached by Walker (2005) who stated that variations in clinical nurse educators’ knowledge, expertise and experience of nursing and teaching influences the learning experiences of student nurses in the clinical arena. This is an important result for nurse educators to consider as it signals the need for appropriate education and mentoring of clinical nurse educators.

### 5.1.4.1.3. Reflection and Reflective practice

Reflection is the term given to cognitive and affective activities that an individual engages in order to understand their situation and/or experience from a new perspective (Lau, Chuk, &Wei, 2002; Wieringa, 2011). The process enables a teacher to critically examine aspects of their teaching after the event in order to improve their practice. I explain in more depth how reflection informs learning in the “Discussion” chapter of this thesis.

All participants reported the importance of reflection as one of the main ways their learning and teaching practice developed. Participants reported reflecting on their teaching
practice regularly and on a consistent basis. Participants were used to reflecting in their nursing practice and therefore transferred this reflection process to their teaching practice as well. Additionally, some participants mentioned the importance of self-reflection in developing and informing their philosophy and purpose in teaching. I provide two exemplars that show the diversity that participants brought to this process and then briefly situate the concept in the teacher education literature.

In the first excerpt, Paris explains how her ongoing reflections of her teaching coupled with critical reading of the literature on teaching and learning were important elements in shaping her teaching practice.

*I see myself as a continuous learner, as a reflective learner. I always look at in a given situation what was my part, what I did well; what could I do differently and how. How could I figure it out and do it differently as I do not always have the answer and building on my own experience. Putting myself in the shoes of the student. Building on what went well. I always ask for feedback from the student to tell me how to be a better teacher during and after the term. I ask how I can help you to learn better as I am trying to meet your learning needs. It is not always about grading. I constantly look for something to read, staff meetings; it is a whole continuum of information to inform you as you get older and more experienced. (Paris. 02-05-2014)*

Paris seemed to reflect on her teaching session at the end of the day whereas the next participant, Althea engaged in a slightly different reflective process.

**5.1.4.1.4. Reflective practice in Teaching**

Althea engaged in the reflective process throughout her teaching session.

*As an educator reflection is an ongoing process. It’s not that I give myself now or at the end of the shift. It’s an ongoing process. I think I reflect throughout the day. When you have an encounter, you talk to the student and you need to reflect about what it means. Am I doing it right, how should I approach this? I have to be open to them to get to know them more personally. It took a couple of years to change my way of teaching and not just lecturing or making threats. (Althea, 12-06-2014)*

Althea states that she engaged in reflection while teaching and continued to reflect on her interactions and her communication with students throughout her day. Her reflections informed her teaching actions and enabled her to review her teaching and make necessary changes. Furthermore, Althea found that reflecting on her practice and feedback from students helped her move away from lecture methods and reduced her emphasis on punitive consequences (*making threats*) for students who failed to produce particular kinds of behaviours. Instead she started to view students as people in need of support. I explored the issue ‘*of making threats*’ with this
participant and other participants. The issue of teaching using fear as a motivator was a recurrent theme and will be addressed in the next section on the Pedagogical context.

5.1.4.2. Un-learning in Order to Teach

The second sub concept is Un-learning in order to teach. I identify the descriptors pertaining to this concept, provide two excerpts to illustrate its significance and will then briefly situate the concept in the literature.

The descriptors pertaining to this concept are as follows:

Use of fear; use of threats; un-learning earlier practices in order to teach more effectively.

All three terms-fear, threats and unlearning-are closely related and could be found in each of the following narratives.

5.1.4.2.1.-Use of fear, un-learning in order to teach

In the first excerpt, the participant describes her experience as a student nurse and its impact on her learning.

_I want to tell the students that I am here to help them. My training was different was very rigid, I did not want that rigidity. I want to be a bit it more relaxed. To provide trust and confidence, to build their confidence. I want to reassure that I am there to assists and they actually do quite well. Assisting them. Not standing and observing and not assisting._ (Jessie. 01-05-2014)

Jessie contrasts her teaching experiences with her experiences as a student nurse. Jessie mentions nurse faculty behaviours such as “standing over” as intimidating. Later in the interview, Jessie also mentioned of feeling ‘uncomfortable, not wanting to be told off’ and mentioned how it negatively impacted her learning. Also, Jessie mentioned that these negative experiences influenced her decision to learn to teach differently which ultimately led her to enroll in a graduate program in teaching.

The words and phrases that participants used to describe their experiences as student nurses and as nurse educators are very telling. Jessie mentions the phrase ‘standing over’ when describing her experience as a student. Other participants also mentioned similar words that a similar sense of having less power and of feeling intimidated. By contrast, Keisha spoke about ‘standing with’ students on describing her own teaching experiences with her students. These words convey strong feelings as a student nurse and their effects on learning as well as illustrating the values and assumptions that nurse educators bring to their teaching practice.
Excerpt 2- Use of fear, un-learning in order to teach

Keisha mentions her experiences as a student nurse and describes feeling fearful of nursing faculty which negatively impacted her learning.

*I did not feel comfortable. My teachers were very rigid. There was no engaging in conversations during conference during orientation or conferences. You bring your syllabus, your assignments and go home. For me learning did not happen there. I did a lot by myself or with my colleagues. I always knew I wanted to teach nursing. I always said that when I became a nurse teacher I would never be that kind of teacher. I did not feel comfortable. I didn’t feel that it was right. I did not feel connected to my teacher. Learning occurs through connection, effective learning takes place through connection. I always held back information because I was afraid of saying the wrong thing or saying the right thing. I was scared of my teachers. I was never sure I was learning or not. (Keisha. 06-05-2014)*

Keisha too mentions the negative impact of the disruptive behaviours displayed by nursing faculty on her learning. Four of the twelve participants reported encountering these kinds of negative experiences from nursing faculty when they were student nurses.

Both excerpts contain descriptions of teachers and teaching that are very distant from the actual meaning of these terms. The term ‘teaching’ means to guide, to enable individuals to grow and develop. The participants’ experiences differed from the understanding of teachers and teaching described in the literature and suggests a culture of compliance rather than one of guidance. I concur with Hansen (1998), that teaching

*As a practice, teaching compels teachers to serve student growth and development, not because of some external authority has declared this to be so, but because of the very nature of the work. The practice obliges teachers to treat student respectfully, at least if we are to talk about teaching rather than about indoctrination, converting or commanding. (p. 649)*

These excerpts reveal many examples of a lack of caring and a rigid approach to teaching by nursing faculty. Also, these scenarios illuminate how the practices of nurse educators over a long period of time and provide some insight into the culture of teaching in nursing and its potentially negative effects on students and their learning. While the discipline of nursing states that caring is the raison d’être of the field, it seems that these students did not feel cared for. In such teaching environments, I question how student nurses can learn to care for others when caring approaches are not modelled by nursing faculty. I explore the culture of teaching in nursing in more depth in a subsequent section on the pedagogical context.
In each example described above, participants engaged in a process of examining and reflecting on their experiences as student nurses, and how these experiences influenced them in adopting a more student-centered stance to their teaching. It seems that participants engaged in a process of un-learning in order to teach differently.

Jan Marie Tyler (2011) described this process of un-learning in a grounded theory study with adjunct faculty in a community college in the United States. Adjunct faculty included part time and sessional and/or contract faculty. The author interviewed seventeen part-time faculty members and she describes unlearning ‘as a social-psychological process that originates within the person’ (pg. 1). This process involves three stages; awakening, examining and reframing, needed in order for the individual to make full sense of her or his experience. Awakening is described as a ‘reality check, a crisis in belief or an unanticipated situation where the individual moves to reflection’ (pg. 33). During the examining phase, the individual engages in self-reflection and considers her/his student’s experiences. In the reframing phase, individuals redefine their teaching relationship with learners, reorient their teaching to meet learner needs and re-engage as a lifelong learner. I saw similar phases in the interview data from my participants in this study. Also, I found that participants with formal knowledge of education were better able to articulate how they reframed their teaching practice.

In summary, participants used a number of sources such as nursing knowledge, experiential, embodied and reflection to inform and enhance their knowledge of teaching and seemed eager to share this learning with others.

5.1.5. The Context

The fifth and final main concept, the teaching context describes the situated pedagogy of participants. The term context in grounded theory methodology pertains to events, circumstances or conditions that make up a situation, the meaning given to it by participants, the actions-interactions individuals take to manage or achieve the desired outcome and the consequences that result from their action (Corbin and Strauss, 2015). This concept includes two sub-concepts; 

Curricular and/or program challenges and the culture of teaching in nursing. Both sub concepts describe the events, the circumstances and the meaning given to them by study participants.

5.1.5.1. Challenges found in the Curriculum and/or Program.

The basic concepts related to this sub concept are as follows:
Instructor-student ratio; Not informed of the overall program; Knowledge gaps in the curriculum; Not informed of the curriculum; Lack of coherence in curriculum; lack of input into curriculum; Lack of professional development and orientation; Not being given the opportunity to assess students prior to taking students into clinical setting; dealing with conflict in the learning and practice environment; clinical placement issues.

Contrary to popular belief amongst nurse educators, clinical placements per se did not pose a challenge for the participants. However, participants reported feeling frustrated when nursing programs used clinical settings that did not effectively support student learning. As described earlier in this chapter, participants reported the high instructor–student ratio as the most cited factor that negatively affected their teaching activities. I address two additional factors which were reported by all participants’ as negatively affecting their teaching. They are as follows; Knowledge gaps in the curriculum and not being informed about the overall program. The knowledge gap in the curriculum emerged as a significant result therefore I provide three excerpts to illustrate the severity of the problem.

5.1.5.1.1. Knowledge gaps in the curriculum

Nine study participants reported concerns with the curriculum specifically related to medication administration. Two participants were not engaged with medication administration; one participant was only available to be interviewed once therefore I could not delve into this issue more deeply with that participant. First, I provide three excerpts as each addresses a slightly nuanced aspect to the problem and then explain each.

Excerpt 5.1.5.1.1.1

They are taught how the drugs work and not how to look and decide when to give the medication and what you are going to follow up with it. For example- furosemide why is the client on it and how are you going to tell the client what the purpose is, and what are you going to have ready at the bedside as the client will be voiding a lot after two hours. It probable is a good example of it being decontextualized and it's my role to deal with every single one of them what you are going to do with this medication. (Sally. 28-06-2014)

Excerpt 5.1.5.1.1.2

This is a stressful situation. I will usually find out based on their past experience, of whether they have been exposed. If I have eight students, I need to find out who has more experience than the other. My slogan is safety, safety, safety. I cannot have my students exposed to medication administration if they don’t know what they are doing. Medication administration itself is an act, anybody can give medications. It’s not the skill. What is most important part is to know what you are giving, to whom, the indications- the knowledge of med administration. In
order to make it safe they have to have backup knowledge before they can administer the medications. It’s not easy because I need to know for sure that you have the knowledge to carry out the act. The act itself is not difficult. (Althea, 19-07-2014)

Excerpt 5.1.5.1.1.3

I think there is a greater risk if I allow student to give medications in week two and they are not prepared. When I do medication for the first time it takes me half hour per student. Throwing that (sic—medications) into the mix in the 2nd week, I don’t feel comfortable doing that. I feel I need to build my students up by doing a proper assessment. In medication administration I will take that risk and wait until they are ready and able to do it. They have been five days in clinical in Year 1 and that was all about bed baths, oral care etc. This will be the first time that they will go through the process of looking up medication, getting the meds, doing the rights. I think it is extremely important that they go through the process each and every step correctly and that they understand the importance of each step. I think in order to do that it takes time. I need them to go through all of the rights with me. I like to spend time with them, make sure what they are giving, why are they giving it, why is there patient getting it, how it’s going to affect their patient before I can let them give meds, it’s about patient safety, it comes down to patient safety. Yes, knowledge has a big part. I think this is a huge, huge part of care and students learning curve. (Margaret. 27-06-2014)

All three participants, Sally, Althea and Margaret raise a number of serious concerns related to the implementation of medication administration in the curriculum. Sally and Althea raise concerns specifically related to the knowledge required of student nurses and student nurses’ ability to make sound decisions in administering medications in a safe manner. Margaret’s major concern is about the lack of adequate clinical exposure for student nurses prior to administering medications. However, all three participants note that student nurses require sound knowledge about medications, deep knowledge of patients in their care in order to make sound decisions about which medication to administer. However, the curriculum determines the point at which students administer medications rather than this timing being related to the actual level of knowledge and readiness of the students.

Also, each patient usually has more than one medication. Therefore, each student needs to have sound knowledge of each medication, their potential interactions and side-effects so as to ensure safe administration of all medications that she/he administers. The clinical nurse educator also needs to have deep knowledge of all the prescribed medications that a student nurse administers to each patient as well as be aware of each patient’s medical condition in order to determine if the medication should be administered or not. Furthermore, medication administration is one task amidst a myriad of tasks that student nurses perform on a daily basis.
and clinical nurse educators instruct and guide each student in the group with a number of other learning activities over the course of a shift. Expectations of undergraduate nursing curriculum specify that student nurses demonstrate an understanding of content, apply their knowledge in a comprehensive and critical manner in practice and develop problem-solving and decision-making skills. However, a lack of curricular coherence exists between program outcomes and the reality experienced by participants which makes achieving these expectations problematic.

Coherence in the curriculum involves creating and maintaining visible connections between classroom teachings and everyday learning experiences and creating contexts that organize and connect learning experiences (Ladson-Billings, 1995). In order to develop coherence in the curriculum nurse educators needs sound knowledge of both nursing and teaching practices, how students learn. Participants demonstrated their nuanced understanding of these issues thereby demonstrating their knowledge, reasoning and judgment of teaching and learning in nursing.

The excerpts also reveal a tension between participants’ knowledge and experience of when student nurses are able to administer medications compared to the timelines determined on the course syllabus. Participants in this study therefore adjusted the timing of when and how student nurses administer medication to meet student learning needs and experience. This practice of adjusting and adapting one’s teaching to meet the demands of the situation denotes the process elements found in this study and are further conceptualised in the central concept of this study.

Like the development process of the curriculum itself, nursing faculty involved in making curricular decisions pertaining to medication administration in nursing programs are not the same individuals tasked to implement the decision in clinical teaching settings. This siloed approach to curriculum development and implementation can therefore have a negative impact on teaching and student learning in the clinical arena.

5.1.5.1.2. Participants not informed of overall curriculum

In the excerpt below, Jessie states that she was not informed of concurrent courses that students were taking; or how each course contributed to student learning in practice. Also, she was not informed of other courses that students had previously taken and therefore missed teaching opportunities for enhancing student’s learning in the clinical arena.
We don’t know what theory is taught in the classroom. We don’t know so we cannot enhance it in the clinical. We are not supposed to know what is taught in the classroom. I liked to know what is being taught but we do not. Clinical instructors are not informed of the curriculum or not given time to process the information. I don’t know the content what they were taught so how can I help students apply what they were taught. This is one of the biggest challenges. (Jessie. 01-05-2014)

From the above excerpt, it seems that each course is treated as independent, isolated event and learning is not scaffolded across the curriculum. Also, communication between and amongst nursing faculty is siloed resulting in a fragmentation of content and pedagogy. Although the clinical component forms a major part of the undergraduate nursing curriculum, clinical nurse instructors remain invisible throughout the decision making processes related to development, design and implementation of the curriculum.

Jessie and nine other participants taught in more than one school of nursing and cited the same concerns about each program that they were not being informed about the overall program and how each course guides the student in their learning to become a nurse. Altogether, this is clearly a significant issue in undergraduate nursing education.

5.1.5.2. Culture of Teaching in Nursing

The second sub concept of the final concept is the culture of teaching in nursing. In this sub concept, participants identify and describe factors that impeded their ability to teach to their satisfaction in the clinical environment. I provide descriptors related to this concept and exemplars to illustrate the concept.

The descriptors include the following:

- Lack of support; feeling isolated; stress and fear; lack of valuing participants’ knowledge; taking risks; the hidden curriculum; lack of current knowledge of nursing practice by nurse educators; racism; lack of voice, hierarchy and authority.

The two most commonly stated problems relate to the undervaluing of participants’ knowledge by other nurse educators and participants’ input not considered in decisions related to the curriculum (which I have just described). I provide three excerpts to illustrate the first problem as each excerpt brings a slight nuanced perspective to the problem. Both problems largely arise from the existing hierarchy and power structures within education departments in nursing.

Excerpt 5.1.5.2.1. Undervaluing participant’s knowledge
In the first excerpt, Sally describes how her knowledge was devalued and how this affected her and her teaching.

_She_ (classroom nurse educator) _said you don’t deserve what a hospital nurse is making because you do not have the same level of life and death decisions. You are only responsible for eight students and the nurse is responsible for real patient in life and death situations. My mouth dropped because in the seven years that I have been teaching my perspective is I am responsible for eight students and they each have two clients thus I am responsible for eighteen patients’ life and death situations. I was going crazy trying to make sure that nobody killed anybody. And to say co-caring nurse responsibility. Under the CNO, I am responsible._ (Sally, 28-06-2014)

In the above excerpt, Sally explains how her level of responsibility and knowledge of nursing and teaching is not valued by the classroom nurse educator. In doing so, Sally identifies the imbalance of power amongst nursing faculty groups and the effect on teaching and learning.

Although, most clinical nurse educators have current knowledge, experience of nursing practices and formal knowledge of nursing, they remain invisible throughout the curricular decision making process in undergraduate nursing programs. Additionally, clinical nurse educators' knowledge of nursing and teaching and their contribution to student learning is ignored as a potentially valuable source of input to the structure and content of nursing curriculum.

**Excerpt 5.1.5.2.2.**

In the excerpt below, Paris also identifies factors that are continuous source of stress and tension for educators teaching in the clinical arena. Paris mentions this power dynamic between and amongst nurse educators, between full-time faculty and sessional clinical nurse educators. These factors underscore the culture of teaching in nursing.

_As a part-time teacher you can’t rock the boat, openly or verbally. Even the strategies put you at risk. You are in a devil’s triangle. If you let your students do it, there is potential issue with CNO (Regulatory Body), if you tell the student don’t do it, and it get back to the lead, you need to justify it to her. You are in this quandary of what do you do. Do you hope and don’t want to hear about it. I practice in a way that I have to do the right thing, I don’t want to make an issue about it, but if I have to do it in a politically astute way. If I have to make an issue I will. We are losing an opportunity to show students how to stand up for patient rights, evidence based practice, a whole hosts of issues that was not identified. It is very difficult for new clinical instructors to navigate this and follow the lead blindly, hope for the best, go with the blinders. It is very difficult to stand up to this as a clinical teacher. We are in a very precarious position where they don’t have to bring you back next term._ (Paris, 09-07-2014)
Paris explains being caught in a quandary among competing interests—the learning needs of the student, the prescribed curriculum, the student’s ability to provide safe care to the patient and the clinical setting. For instance, if a student performs a procedure\skill but lacks adequate knowledge and reasoning in doing so, the student and clinical instructor are both answerable to the regulatory body. However, if the student does not practice the procedure, the clinical instructor needs to inform and defend her position to the course lead who may or may not have current knowledge of the practice setting or may not have adequate knowledge about the student’s nursing abilities. In this situation, Paris stated that she made her decision based on her values and assessment of the situation.

Paris has been teaching for over six years and has taught in three schools of nursing and in varied undergraduate nursing programs. Her experiences teaching in the clinical arena are similar in all these education institutions and denote the extent of this culture of teaching.

Similar to Paris, ten of the remaining eleven participants were hired as contract sessional teachers. Raising issues or concerns is problematic for a contract teacher as they too could find themselves in a ‘devil’s triangle’. Although all participants alluded to the conflict, I found that Paris most clearly identified the sources of the conflict and its negative consequences for student learning and the clinical nurse instructor. The challenge for clinical nurse educators, new and seasoned alike is learning to navigate the “triangle” while ensuring student nurses learn to provide safe care. In addition, clinical nurse educators have legal responsibilities towards the patients and students caring for patients (Patton, 2015) that need to be explicitly acknowledged by nursing education departments.

**Excerpt 5.1.5.2.3.**

In the next excerpt, the participant describes her teaching environment, the influences and constraints on her teaching practice. Adele states that both students and clinical nurse instructors lack input into curricular decisions.

*Students feel they don’t have a voice. As a clinical instructor I do not have a voice. I don’t. I don’t. Even when I question some of the practices that I see on the course outline, it does not affect anything. This authoritative culture teaches students this is the culture of nursing. To be like one of us you have to be like us. In nursing, we are supposed to be patient centered care, advocate for the patient. But we are sending another message- do not do. The hidden message seems to be more powerful than the obvious message- advocate for the patient when the hidden message is follows the rules. Follow the rules. And students are smart and they know what is happening. I talk to my students about this as well. They are very frustrated with*
the system. It has to come from the students. If you do not follow the rules you do not get hired the next semester. (Adele. 12-05-2014)

This excerpt highlights the lack of input into curricula and clinical issues and its consequences for student learning. Such experiences do not encourage students to become an advocate for patients’ and/or becoming change agents in the health care system. Also, Adele mentions the phrase “hidden message” that evokes the idea of the hidden curriculum. The term hidden curriculum has varied meanings in teacher education literature but I provide one explanation here that illuminates the concern. Hidden curriculum is a term used to indicate the non-explicit social and cultural values and norms that permeate the curriculum content and the teaching process. Students internalize these unspoken social and hierarchical norms within the nursing environment in order to function effectively as members of this smaller society. I expand in more depth on the role and impact of the hidden curriculum in the “Discussion” chapter of this thesis.

5.1.5.3.4. Participants learning experiences as student nurses

In order to understand more broadly the culture of teaching in nursing over time, I inquired about participants’ earlier experiences as student nurses, and some participants shared these. While a few provided positive anecdotes of their student days in nursing, four participants provided a number of negative accounts of their student experiences in nursing. I provide two exemplars to illustrate the effects on the participants.

Excerpt 5.1.5.3.4.1.

Participant Keisha discusses her experiences as a student nurse and how it negatively impacted her learning in the clinical arena.

I had some horrible teachers as a student nurse. It was a nightmare with some of the teachers I had. I always said to myself that I would never be like that. I knew I wanted to teach and I always said that I would never be that kind of teacher, and I will never do that to my students and I kept that promise to myself. That’s why I practice as a teacher in a manner as I never want my students to go home and be stressed out and not want to go to clinical. One day I was at hospital (sic-A) and in the nursing station. The teacher told me that I would make an awful nurse as I was an awful student and she failed me. In front of everyone in the nursing station. I didn’t do anything wrong, I was talking to the nurse about my patient. I went home stressed out; we did eight weeks in one hospital and the other eight weeks somewhere else. I had this teacher for the first eight weeks and then I went to a med-surgical floor for the next eight weeks with another teacher. This teacher would call the other teacher to fail me that I am not a good student. The teacher told me, she likes to see the student and make her own decision. At the end of the semester she told me this. (Keisha, 19-06-2014)
On reflecting on her student experiences, Keisha decided that she wanted to learn to teach in order to teach differently. Keisha took courses on teaching and learning and constantly sought ways to improve her teaching.

The above scenario also reveals the power imbalance between teacher and student and its implications for student learning, an issue I explore in the “Discussion” chapter of this thesis.

Excerpt 5.1.5.3.4.2.

Adele enrolled in graduate programs in nursing and teaching programs sequentially over a short period of time. Adele describes her student experiences in each program and in the following excerpt contrasts her experiences in each program and details its effect on her learning.

*I created my own learning environment. The learning was not happening in the class (sic-nursing). It was mostly outside of the class rooms setting. I did the assigned readings, papers to submit, I did really well in that part. But learning was outside of the classroom. It was funny when I took my first class at (sic- education department). I was very anxious. I was in the class and waiting for somebody to walk in and stand above me and tell me what I was supposed to do. My anxiety was high as I thought what I was not able to accomplish all of the things I needed to be successful in the class. Then the professor walked in. She was such a friendly person, open individual and she wanted to get to know us as people, who we are and where we come from, our backgrounds. I think the whole idea of being level with other people made this very welcoming. This has been continuous since the first class I have been there. The learning environment is created by faculty. People being able to talk to you, to meet with you, to guide you. I think it makes a huge difference. Being open to ideas, being open to different thinking styles. Whereas when you go to (sic-graduate program in nursing), you are not seen as equal, that’s how it feels. You are just here to complete the course work and go to the workforce and be a nurse. (Adele, 12-05-2014)*

Adele compares and contrasts her student experience in each graduate program. The participant felt her ideas were welcomed in her program in education where the approach to teaching seemed more student-centred while as a graduate student in nursing, she was expected to remain passive, quiet and listen rather than respond to, or interact with her peers or the teacher. In general the nursing program seemed to reflect a more transmissive approach to teaching.

In examining Adele’s experiences as a student in each case, it appears that each graduate program offered a different understanding of learners and learning. In her education program, Adele stated that her knowledge was acknowledged and used in building new knowledge with the class. The school of education seemed to offer a student centered approach where co-learning between teacher and students occurred. By contrast, in Adele’s graduate program in
nursing, a teacher centered approach was used where only the teacher’s knowledge is considered important. The knowledge that students bring is ignored and dismissed thereby exacerbating the inherent power difference between teacher and students.

5.1.5.2.4. Non-inclusive practices

The second sub concept that I will discuss pertains to the issue of racism and non-inclusive behaviours. Four of the twelve participants’ reported experiencing racism as nursing students or in their role as nurse educators.

In the following excerpt, the participant describes her experience of racism as a clinical nurse educator.

*If you are not white you are not right, if you are not white you are not right. If you are not white you are not educated, if you are of a different ethnicity and if you are educated we are supposed to keep you down here. It’s seems we don’t have the same skills and abilities as you. Give us the opportunity, give us a chance. It’s not there, it going to take a long time to change. Look at the managers in the hospitals. Look at the schools of nursing, it no joke. Among nursing faculty, how many people of color do you see? We might have bright ideas, students do well with us, we are student centered but it not seen it’s not appreciated. If you are white you are right and it makes you more qualified. I realised this over time.* (Savannah, 15-03-2014)

Savannah expresses her concerns about discrimination and notes the lack of diverse cultural representation both in nursing administration and among nurse faculty in education institutions. The issue of racism amongst nurse educators is missing in the literature in nursing education.

Throughout the transcripts, I found issues of exclusion and incivility. This result echoes findings in the nursing literature describing a culture of incivility in nursing education. Clark and Springer (2010) conducted a qualitative study and surveyed 126 academic nurse leaders from private colleges, community colleges and university in a state in the U.S. Academic leaders included Deans, chairs and directors from associate and undergraduate nursing programs. The authors examined certain behaviors exhibited by students and faculty in nursing programs and the role of leadership in preventing and addressing incivility in nursing education. Incivility is understood as the “rude or disruptive behaviors that often result in psychological or physiological distress for the people involved” (Clark as cited in Clark and Springer, 2010. p 318). Seven themes emerged related to nursing faculty incivility towards other nursing faculty. The most common offences of incivility included overt rude and disruptive behaviors and
avoidant, isolative and exclusionary behaviors. The authors noted the lack of leadership in nursing education in addressing these issues.

In summary, I have described five major themes in this chapter so far that emerged from the data that highlight the knowledge and teaching practices of clinical nurse educator participants.

5.2. Development of Central Concept in This Study

In this section, I describe the theorizing process used in this study and introduce the central concept. Theorising is a practice, an interpretive process that that guides researchers in developing an explanatory theory from the data (Charmaz, 2010). I re-introduce the conceptual framework in order to refresh the reader’s understanding as to the situation of each of the main concepts that emerged from the results. The central concept in this study is as follows: The pedagogical practices of clinical nurse educators and the navigation of constraints in complex educational institutions.

5.0.1.1. Diagram of study’s conceptual framework

<table>
<thead>
<tr>
<th>Central concept</th>
<th>Main concepts</th>
<th>Sub-concepts that emerged from the data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pedagogical practices</td>
<td>5.1.1. Pedagogical knowledge</td>
<td>5.1.1.1. Instructional Activities. 5.1.1.2. Knowledge in Action 5.1.1.3. Teaching milieu.</td>
</tr>
<tr>
<td></td>
<td>5.1.2. Building Pedagogical Partnerships with students</td>
<td>5.1.2.1. Pedagogical partnerships with student nurses. 5.1.2.2. Establishing professional boundaries with student nurses.</td>
</tr>
<tr>
<td></td>
<td>5.1.3. Ethics in teaching</td>
<td>5.1.3.1. Personal\Professional values of clinical nurse educator participants. 5.1.3.2. Balancing the learning needs of students with safe care. 5.1.3.3. Teaching milieu.</td>
</tr>
<tr>
<td></td>
<td>5.1.4. Learning to teach</td>
<td>5.1.4.1. Knowledge of teaching 5.1.4.2. Un-learning in order to teach.</td>
</tr>
<tr>
<td>Navigating constraints found in complex education environments.</td>
<td>5.1.5. The Context</td>
<td>5.1.5.1. Challenges in Curriculum and program. 5.1.5.2. Culture of teaching in nursing.</td>
</tr>
</tbody>
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Central concept. The pedagogical practices of clinical nurse educators and the navigation of constraints in complex educational institutions.
On further conceptualizing the study’s five main concepts, I found that three of the five concepts, *pedagogical knowledge, pedagogical partnerships*, and *learning to teach* showcased participants’ knowledge; these are therefore subsumed under the new heading *Forms of Knowledge* and discussed in the next chapter. *Ethics in teaching* is a broad overarching concept, distinct from the study’s other main concepts, and is therefore discussed separately. Additionally, in grounded methodology researchers are advised to re-examine existing categories and check for results that do not fit the existing categories (Charmaz, 2010). On further examining all the transcripts, I found that participants contrasted their teaching approach with nurse faculty teaching in the classroom. This result did not fit into existing categories and is therefore addressed under a new category, *Approaches to teaching*. The study’s fifth and final concept, *The Context* is also found within the study’s central concept.

In grounded methodology, a core category is a central concept that is sufficiently abstract, and summarizes in a few words main ideas expressed in the study. In other words, the central concept emerges from the integration of the main concepts in the study to form a cohesive and explanatory theory (Corbin and Strauss, 2015). Researchers analyze events, how persons define or give meaning to these events, the action-interaction of persons to adapt and/or adjust to the conditions in which they occur and the outcomes that results (Corbin and Strauss, 2015). Therefore conditions, actions-interactions, and consequences are interdependent and enable the researcher to explain the meaning of events from the participants’ perspective. Events and conditions relating to the process and contextual elements are essential components in creating a theory from the data. Process occurs when persons act and interact to circumstance\conditions that they encounter. Process represents a responsive, dynamic response and captures how persons adapt\adjust to changes (Corbin and Strauss, 2015). The process elements in this study relate to how participants built partnerships with students and how participants adjusted their teaching to meet the learning needs of students.

Context is a conceptual term used in grounded methodology to denote relationships between concepts. Context includes events, circumstances or conditions that make up any situation; the meaning given to it by participants, the actions and interactions individuals take to manage or achieve the desired outcome and the consequences that result from their action. Context is also expressed in the reasons that persons give for what they think, say, feel and do in response to problematic situations or events that they encounter (Corbin and Strauss, 2015). In
this study the contextual elements relate to the teaching milieu and the culture of teaching in nursing.

Goulding (1998) explains the meaning of theory using grounded methodology as a, way of revealing the obvious, the implicit, the unrecognized, and the unknown. Theorising is the process of constructing alternative explanations until a best fit that explains the data most simply is obtained (p. 52).

In this study, I have used Charmaz’s (2010) constructivist-interpretive approach to creating a substantive theory, and where the theory creation rests on participants’ experiences, thoughts and responses and the researcher’s interpretation of events and situations. The substantive theory in this study is; The pedagogical practices of clinical nurse educators and the navigation of constraints in complex educational institutions. The central concept consists of two interrelated processes, the pedagogical practices of clinical nurse educator participants and how they negotiated constraints that they encountered while teaching in the clinical arena.

Furthermore, Punch (2009) explains that theory could serve two purposes a methodological and/or substantive purpose. Researcher's in using a methodological approach to theory make connections between the research questions and the methods used to collect and analyze data whereas a researcher's using a substantive approach engages in describing and/or explaining important elements that emerge from the data that lead to generation of a theory from the data. Grounded theory consists of both, methodological and substantive elements of theory and in this study I have used both understanding of this term.

Theories range according to levels of abstraction from more formal, middle range or substantive theory (Corbin and Strauss, 2015). A formal theory is more generalised and crosses many disciplines whereas a substantive theory is more localised and contextual. Theory remains relevant for explaining phenomenon and providing concepts and hypothesis for future research. In this study, the central concept that emerged from the data reflects a substantive and localized explanation of the participants’ pedagogical experience while teaching undergraduate student nurses in the clinical arena.

Summary of chapter

In summary, this chapter consists of three major sections. In the first section, I described my process in developing the main concepts and the conceptual framework in this study; in the second part I included excerpts from participants, their activities, knowledge of teaching and the
teaching milieu. I provided illustrations of similarities and important differences in teaching context amongst participants. Also, I situated some important concepts that emerged from the results in the broader literature. In the final section, I described my process in conceptualising the main concepts and the emergence of the central concept from the results. In the next chapter, I expand on some important results and discuss in depth the central theory that emerged from the results.
Chapter 6.0 Discussion

Overview of Chapter

The data revealed that teaching in the clinical arena is both multidimensional and layered and that clinical nurse educators require a substantial amount of knowledge and experience in nursing and pedagogy in order to teach effectively in the clinical arena. On examining the data, I found problems, paradoxes, and areas of concern. In this discussion, I examine important elements that emerged from the data using a critical pedagogical approach. Also, I expand on some ideas found in constructivism and critical pedagogy introduced in the “Literature” chapter. In addition, I have drawn on the work of education scholars such as Fenstermacher (1994) and Donald Schӧn (1983) to explain important elements that emerged from the data, such as forms of knowledge and reflection in teaching.

This discussion focuses on the study’s central concept, The Pedagogical Practices of Clinical Nurse Educators and the Navigation of Constraints in complex Educational Institutions and explicates the various intersections among the study’s five main concepts and its central concept. The discussion that follows is therefore organized around the following four concepts.

6.1. Forms of Knowledge Portrayed by Participants
6.2. Ethics in Teaching
6.3. Approaches to Teaching, and
6.4. The Context.

In the following section, I explain each concept and situate each in the broader literature.

6.1. Forms of Knowledge Portrayed by Participants

In this section, I explain the varied forms of knowledge portrayed by participants. Knowledge of teaching emerged as a significant finding in this study—a result contributing in significant ways to current nursing education literature as clinical educators’ knowledge of teaching is largely absent from consideration in that literature. Also, it seems those nurse educators teaching in the classroom are unaware of the varied forms of knowledge used by clinical nurse educators, and therefore they tend to undervalue teaching in the clinical arena as well as the contribution made by clinical nurse instructors to student learning in that arena.

In this thesis, I explain the concept of knowledge to mean “the mental state and activities of teachers” (Fenstermacher, 1994, p. 34). Most teacher educators acknowledge that teachers use
the following three forms of knowledge: factual or propositional knowledge; knowledge of how to do things; and knowledge by acquaintance (Fenstermacher, 1994; Toom, 2012). Cochran-Smith and Lytle (1999) delve further into the forms of knowledge displayed by teachers, and they provide a framework to examine and explain these forms of knowledge used by teachers in their work. Cochran-Smith and Lytle (1999) explain teachers’ knowledge as knowledge for practice, knowledge in practice, and knowledge of practice. I conceptualize the knowledge portrayed by nurse educator participants in their teaching using the first two forms of knowledge.

6.1.1. Knowledge for Practice

The first concept, knowledge for practice, is also known as foundational, formal knowledge (Fenstermacher, 1994; Richardson, 1996), or teacher knowledge/formal (Cochran-Smith & Lytle, 1999; Freeman, 2002). This form of knowledge includes a teacher’s knowledge of subject matter, learning theories, pedagogical methods and models, knowledge of assessment and classroom management. Knowledge for practice encompasses the knowledge needed for a teacher to perform her/his work.

In this study four participants—Jessie, Adele, Savannah, and Paris—received their graduate degrees in education. These four participants were able to easily and clearly articulate and describe in detail their methods of assessment as well as how and when they assessed students. Also, these participants provided a number of teaching strategies used to support students’ learning in the clinical arena. Jessie, Adele, Savannah, and Paris further explained how they tailored their teaching to meet the learning needs of individual students and to meet the needs of students across student groups in different undergraduate nursing programs. It seems that formal knowledge of teaching enabled these four participants to bring a high level of comprehension of nursing knowledge to their students and enabled them to speak with conviction and confidence, and to convey an appreciation of the contemporary relevance of their subject (Prior, 1965).

In addition, these four participants taught in more than one undergraduate nursing program and in more than one school of nursing. These participants were able to compare and contrast strengths and weaknesses in each undergraduate nursing curriculum and across nursing programs. They offered insights and recommendations in each program in order to improve student learning in the clinical arena. On the other hand, participants with graduate degrees in nursing only had learned to teach mostly through trial and error and the impact of these influences is described in subsequent sections in this chapter.
Learning to teach through trial and error was also reported by other nurse educator researchers. Nurse researchers Cangelosi, Crocker, and Sorrel (2009), Fanutti (1993), Kramer (1996), McDonald (2004), Pauling (2006), Ruby (2000), Walker (2009), and Young (1999) report that most nurse educators are hired for their professional knowledge of nursing and may or may not have knowledge of teaching or teaching experience.

6.1.2. Knowledge in Practice

This second concept of knowledge is also known as practical, craft, situated pedagogical knowing (Fenstermacher, 1994; Lytle & Cochran-Smith, 1992; Richardson, 1996; Tirri, Husu, & Kansanen, 1999), tacit or pedagogical content knowledge (Shulman, 1998), and knowledge in action (Cochran-Smith, 2003; Cochran-Smith & Lytle, 1999). Unlike a teacher using formal knowledge, knowledge-in-action involves the teacher actively engaging in constructing her/his knowledge of teaching while performing her/his work (Cochran-Smith & Lytle, 1999; Clandinin & Connelly, 1987, 1992).

Knowledge in practice includes the “how” and “why” of teaching. One of the main assumptions found in this form of knowledge is that teaching is an “uncertain and spontaneous craft, situated and constructed in response to the particularities of everyday” school life (Cochran-Smith & Lytle, 1999, p. 262). How the teacher tailors her/his teaching and transforms content depends on the teacher’s understanding of the disciplinary content, knowledge of nursing practice, and interpretation of her/his learners’ response to the content and instruction. The assumptions that underpins this form of knowledge is deeply embedded in a constructivist view of the world. In a constructivist view, teachers construct their knowledge of teaching through examining and describing the opportunities and challenges they encounter in their everyday teaching and through reflecting on ways to improve their teaching. These assumptions are a sharp contrast to the assumptions that underpin a traditional approach to pedagogy discussed in the Literature chapter. Furthermore, I contrast the assumptions found in a traditional and constructivist approach in more detail in the section “Varied Approaches to Teaching” found later in this chapter.

In addition, teachers’ construction of knowledge is manifested in their reasoning and decisions. In this study, participants’ reasoning about their teaching was evident in their actions and decision-making process. This is an important finding, as the reasoning of nurse educators has not been described in nursing education literature to date. Also, most nurse educators seem
unaware of this form of reasoning embedded as it is in the teaching practices of seasoned clinical nurse educators.

The practical knowledge of teachers is a multifaceted concept with subtle nuances. Also, different education theorists explain and describe each form of practical knowledge quite distinctly; therefore I focus on particular education scholars’ understanding of practical knowledge that best explains the data. For instance, Schön (1995) suggests the importance of reflection in a teacher’s thinking, which I describe later in this section.

Participants’ knowledge of teaching emerged as an important result and therefore I describe six forms of practical knowledge portrayed by participants:

*Pedagogical content knowledge;*

*Situated pedagogical knowledge;*

*Tacit knowledge;*

*Embodied knowledge;*

*Experiential knowledge;* and

*Reflective knowledge.*

The transcripts reveal how participants viewed the importance and significance of their knowledge of teaching in the clinical arena. I provide excerpts from the data to illustrate each form of knowledge.

**Pedagogical content knowledge.**

Shulman (1987) coined the phrase “pedagogical content knowledge” (PCK) in the 1980s and recognized that teachers’ wisdom of practice was an important source of knowledge for teachers to draw upon in their teaching. Shulman describes PCK as “the blending of content and pedagogy into an understanding of how particular topics, problems or issues are organized, represented and adapted to meet the diverse interests and abilities of learners and presented for instruction” (cited in Cochran-Smith & Lytle, 1999, p. 256). Teachers create this form of knowledge when they transform content into an appropriate representation that facilitates students’ understanding. In the excerpt below, Paris describes how she teaches integrating the nursing process model in practice. This excerpt reveals Paris’s ability to transform content and blend that content with her instruction:

*Based on what are the core foundations they have, what is realistic that you can hook on? Like a Christmas tree. Their tree is like a Charlie Brown Christmas tree. It is not very big and broad. It is very spindly, so you have to say what...*
branches of that Charlie Brown Christmas tree do they have? What concepts and activities can I put on there that is going to stick? Because if you put stuff on there but there are no branches or if the branches are too weak, they are going to fall off. It’s not about what you know and it’s not about doing the job, but it is doing it in a professional way and focusing on a very particular slice. (Paris, 02-05-2014)

Paris explains how she prepares and plans course content with instruction to ensure that students understand and integrate the content taught in class in their practice. For example, in instructing students about integrating the nursing process model in their practice, Paris explains that as she observes and assesses her learners, she transforms the content and pedagogy in order to facilitate students’ understanding of integrating aspects of the model in their practice. Paris showcased how she constructed her knowledge of content and pedagogy so as to facilitate learning. Also, Paris highlights the importance of altering the representation of content as needed in order to meet the diverse learning needs of her students.

The theoretical assumptions that underpin teachers’ construction of their pedagogical knowledge are very different from the assumptions that underpin a traditional approach to teaching and I contrast the assumptions found in each approach in subsequent sections in this chapter.

**Situated pedagogical knowledge.**

Another facet of practical knowledge is the notion that it is situated. Situated pedagogical knowledge is specific to a particular teaching context (Richardson, 1996) and focuses on instructional activities.

In the excerpt below, participant Sally describes her knowledge of instructing students in performing a physical examination of a patient:

> I have each of them do a head-to-toe assessment. Sometimes I interrupt them in the middle of their assessment and say the patient has a scar on their knees, your hand is right there, I think you have something else in your head. Then I give them direction, I stop and coach further and watch their face and see if they are catching it. It is bringing them to a point of recognizing something that I am observing that they should be observing. They need to be drawn to that point. To the student caring for a patient with the scar on the patient’s knee that she [the student] wasn’t observing. I said what questions are you going to ask the client now? (Sally, 28-06-2014)

In this excerpt, the student nurse seems unaware of the patient’s previous knee surgeries and Sally guides the student to accurately examine the patient. The student seems unaware that a
patient with double knee surgery may have difficulty with ambulation; nor does the student know the type of questions to pose to the patient in order to understand the patient’s mobility restrictions. Sally guides the student in developing and posing the questions to the patient. Sally’s knowledge of the patient, the patient’s medical needs, and the student’s learning needs guide her in how she instructs the student. In doing so, Sally guides the student in learning more about the person and his/her response to surgery so that the student can learn how to plan appropriate nursing interventions tailored for that patient. Sally’s knowledge and observations guided her in constructing her pedagogical response in this situation.

Sally has been teaching in the clinical arena for over eight years and has approximately thirty years of nursing experience. It seems that Sally’s teaching experience guides her in the clinical situations that students encounter, her assessment of learners, and in her teaching interventions.

**Tacit knowledge.**

Participants revealed their tacit knowledge of teaching through their actions and decision making. As mentioned briefly earlier in this thesis, Schön (1995) states that our knowing is ordinarily tacit, implicit in our patterns of action, and “in our feel for the stuff with which we are dealing...the workaday life of the professional practitioner reveals in its recognition, judgment and skills a pattern of tacit knowing-in-action” (p. 29). Schön explains that tacit knowledge is thought intertwined with action where the teacher mediates ideas and constructs meaning and knowledge that guide her/his action. These processes seem to occur concurrently and seamlessly. Unlike the former two concepts of knowledge in action, Schön describes this form of practical knowing as the blurring of lines between knowledge generation and knowledge use.

Tacit knowing is understood as the accumulation of the individual’s teaching experiences and events. Tacit knowledge could also include teachers’ values and beliefs that have arisen from their experience within the teaching context (Toom, 2012). Tacit knowledge is characterized by the following three characteristics: it is acquired without direct input from others; it is concerned with how best to complete tasks under certain conditions; and it is expressed without being explicitly communicated (Elliott & Stemler, 2008). For instance, in the excerpt below, Savannah’s tacit knowledge of teaching is seen in her reasoning and decision making when she encounters an unsafe medication situation in the clinical arena. Savannah describes how, on checking the medication with the student, she realizes that a medication error has occurred:
I am checking the medications with her, and she said the patient refused. I am looking at the MAR and thinking to myself, Why is the patient refusing her nitroderm patch? She [sic-the student] said, Well, it is a nicoderm patch....As you [sic-the student] discovered the error, you have to change it, you have to stop it, rewrite the MAR. You need to stop the error from continuing.
(Savannah, 15-03-2014. See “Results” section for the entire excerpt)

Savannah realizes the several problems inherent in this situation: problems with the transcription of the order, the staff nurse’s response to the student, and the student nurse’s lack of knowledge about the medication. Savannah realizes that the student needed guidance in order to administer the medication safely to the patient. In this situation, Savannah’s deep knowledge of teaching informed her reasoning and decisions as she considered the situation, its implications, and her actions, all in a just-in-time way. Later on in the interview, Savannah described how she reviewed the physician’s order and assisted the student nurse in correcting the medication error. In this situation, Savannah drew upon her tacit knowledge of teaching in assessing the situation and guiding her teaching interventions. Savannah has been teaching in the clinical arena for over seven years and seemed to draw on her formal knowledge of teaching, previous teaching experiences, knowledge of nursing, and understanding of student nurses to guide her actions. Savannah’s action also highlights the participant’s contribution to student learning in the clinical arena by ensuring that the student learned how to provide safe care to the patient.

In the following two excerpts, I contrast how Adele and Jackson made decisions related to student-patient assignments in the clinical arena. Making student-patient assignments is a regular and daily occurrence for clinical nurse educators and is therefore an important issue to discuss. I contrast the decision made by Adele, a more seasoned clinical educator participant, with a decision made by Jackson, a new clinical nurse educator participant. I found that seasoned participants in particular, such as Adele, were able to anticipate and manage student questions about their learning more adeptly than new clinical nurse educators.

In this excerpt, Adele explains the reasoning behind her decision.

I ask the students to review their charts and find the patient they are interested in. Once they find a patient, they need to be able to justify their learning to me. I do this every week and every second day of clinical; they have to come and inform me. (Adele, 11-08-2014)

Adele enables each student to identify his/her learning needs for the day. For instance, if a student needs to learn and/or practice a particular skill such as changing a dressing, the student
looks for this learning opportunity from among the patients on the nursing unit. The student then informs Adele about her/his learning goal. Adele reviews each student’s daily learning goal with the selected patient’s nursing care needs, then reflects on how this selection would enable each student to accomplish her/his learning objective.

In contrast, Jackson a new clinical nurse educator, uses a more traditional approach in his student-patient assignment. He comments:

I assign students based on complexity and a match with each student’s skills. I research information on the resident and it takes me two hours, charts, kardex per patient. Even if I am quick it takes me hours. (Jackson, 26-03-2014)

Jackson seemed to use a more traditional approach of assigning student nurses to patients that is based on his own assessment of the learners rather than enabling each student to identify for themselves, what their specific learning goals need to be for the day.

In contrasting Adele’s and Jackson’s responses to making student-patient assignments, Adele adopted a more student-centred approach in making her decisions than Jackson. Adele’s reasoning is illustrated in her decision and actions and appears to take into account in-depth knowledge of her learners, their abilities, and their learning needs as she instructs each student to seek out patients that could address their particular learning needs. In doing so, Adele assesses and guides each student in her/his thinking and learning. It seems that Adele’s thoughts about her learners are intricately linked to her ongoing instructions, whereas Jackson seems more preoccupied in ensuring that students develop certain predetermined skills and objectives outlined in the curriculum.

Furthermore, it seems that Adele’s graduate studies in education and ten years of teaching experience enabled her to more fully apply her tacit knowledge of teaching. Specifically, Adele seems to draw upon her past knowledge and experiences of teaching coupled with her current assessment of each student’s performance in the clinical context in making her decisions.

I found that the seasoned clinical nurse educator participants, and this includes Nicky, Sally, Jessie, Adele, Keisha, Savannah, and Althea, revealed their tacit knowledge of teaching in their decisions. These participants had been teaching in the clinical arena between seven and fourteen years and seemed to draw upon their teaching experiences to guide their teaching interventions. These participants provided many examples from their teaching that uncovered multiple factors they considered in making their decisions.
Cochran-Smith and Lytle (1999) report that the knowledge teachers’ use in their work is manifested in their actions and decisions. This form of knowledge is generated from and in the work of experienced teachers. The authors state that the actions and activities of competent teachers as they deal with problems they encounter in the selection of appropriate teaching student strategies and making connections between concepts [sic-that] are connected to one another. While the “how” is deliberation and consideration're-consideration and is the conscious reflection on student’s activities and learning in order to teach in new situations. (p. 268)

Although all participants referred to teaching in the clinical arena as being complex, I found that seasoned participants were more aware of each student’s knowledge, abilities, and areas of improvement. For instance, Nicky, Sally, Jessie, Adele, Keisha, Savannah, and Althea described in detail how they could accurately place students with their patients as well as plan and organize their time efficiently in order to spend adequate time with each of the eight students in the group. This, in turn allowed them to guide each student in their learning and gave each student the opportunity to learn, practice, and integrate new knowledge. These participants seemed to make sense of new situations by finding similarities and parallels that they could connect to previous events and to a variety of other information, thus contextualizing the learning experiences for their students (Schön, 1995). Also, these participants seemed more adept at creating and developing their pedagogical responses in a timely manner.

I found that participants’ decisions varied from simple to complex according to the situation and contextual circumstances. In some cases, participants had time to think and ponder while at other times they needed to make a well-informed decision within a short time frame. In making a decision, it seems that participants needed to consider the many options available in each situation. Specifically, participants needed to critically evaluate each option, anticipate the potential outcome of each option, and examine their reasoning for choosing a particular option before implementing their teaching intervention. The decision-making process seemed complex and participants were required to make such decisions on a regular and consistent basis.

Participants mentioned six factors that hindered them from making a considered decision. The first and most problematic factor was the number of students in each clinical group. Participants reported that having eight students in a group was problematic as they had to simultaneously consider each student’s learning needs and consider the context in a timely
manner within busy nursing units. The other five factors that hindered the participants in making good decisions were noted as (1) the increasing acuity (illness) and complexity (multiple medical conditions) of the patients; (2) the lack of adequate student preparation to care for patients with complex needs; (3) the decrease in the patients’ length of stay in the hospitals, which resulted in participants having to make new student assignments more frequently; (4) participants’ lack of knowledge and/or understanding of the polices of the particular nursing unit; and (5) lack of support from the academic institution.

Overall, I found that participants with formal knowledge of teaching and six years of teaching experience (Jessie, Adele, Paris, and Savannah) seemed more adept at making complex decisions in their teaching. I also found that seasoned participants with nine to fourteen years of teaching experience (Nicky, Sally, Keisha, and Althea) made good decisions. However, it seems that teaching experience alone does not ensure effective teaching or good decision making and that nurse educators with additional formal knowledge of education seem to create their knowledge of teaching in a more systematic manner and, arguably, teach more effectively.

Embodied knowledge of teaching.

Some participants spoke about their embodied knowledge of teaching. I first explain the concept of embodied knowledge and provide one excerpt to illustrate Jessie’s embodied knowledge of teaching.

Education scholars Connelly, Clandinin and He (1997); Clandinin and Connelly (1987, 1992) and Schön (1995) note the importance of embodied knowledge of teaching. Schön (1995) explains embodied knowledge:

(There is-sic) knowledge implicit in action and artistry—that artistry is a kind of knowing…implicit in our patterns of action and in our feel for the stuff with which we are dealing…the workaday life of the professional practitioner reveals in its recognition, judgment and skills a pattern of tacit knowing-in-action. (p. 29)

This deep and integrated form of knowledge enables teachers to recognize patterns of behaviours and make reasoned decisions. In the following excerpt, Jessie shares her knowledge with the student in assessing a newborn baby and guides the student in listening to heart sounds and counting respirations.

*The assessment of a newborn is difficult such as assessing respiratory and heart rate. They would listen and time the breath sounds and then the baby*
would sneeze and they would lose track. They [sic-the students] would tell me the respiration is 30. The lab is different from doing it on the real baby. So they need to count the respirations. (Jessie, 23-06-2014)

In this scenario, Jessie revealed her embodied knowledge of nursing and teaching in performing an examination of the newborn child. Jessie quickly moved from using procedural knowledge of examining a newborn baby and relied more on her bodily knowledge in performing an examination of the baby. Also, Jessie seemed to move quite seamlessly from assessing the students’ lack of knowledge of examining the baby to instructing the students on how to listen to the baby’s heart sounds. Jessie seemed to move quite effortlessly in her teaching, from assessing the students’ needs to guiding them with their examination of the newborn. Jessie has taught in the clinical arena for over ten years and seemed to build her knowledge of teaching from both her formal studies in education and her teaching experiences to guide her teaching interventions. Participants with formal knowledge of teaching seemed to make decisions and teaching interventions using their knowledge of teaching and not solely depend on their knowledge of nursing. These participants seemed to guide their students in a more comprehensive and arguably more effectively. This finding adds a new insight to the nursing education literature as previous research (e.g. Walker, 2005; 2009) reported that most nurse educators use mainly nursing knowledge to make decisions in their teaching practice.

**Experiential knowledge of teaching.**

Experiential and reflective knowledge were the two most common forms of knowledge that participants reported in their teaching. I provide one illustrative excerpt of each form of knowledge and discuss its importance to the participants.

Clandinin and Connelly (1992) and Fenstermacher (1994) provide slightly nuanced concepts of experiential knowledge, and I have adopted the concept suggested by the former as it relates more to these participants’ contextual experiences. Clandinin and Connelly (1992) explain experiential knowledge as follows:

> It is knowledge that reflects the individual’s priori knowledge and acknowledges the contextual nature of that teacher’s knowledge. It is a kind of knowledge carved out of, shaped by, situations; knowledge that is constructed and re-constructed as we live out our stories and...through the process of reflection. (p. 10)

According to Clandinin and Connelly’s (1992) concept of experiential knowledge,
teachers develop and create personal knowledge of their teaching while engaging in their work and demonstrate this form of knowledge through their deliberations and reflections. Experiential knowing enables teachers to act and think wisely while teaching. In the excerpt below, Karin describes how her teaching experience guided her in observing, assessing, and instructing a student nurse with administering medications.

We talked about the same meds day after day—Lasix, beta-blockers, every day she would forget to tell me the patient’s heart rate…or the reason the patient was on a drug. (Karin, 05-05-2014)

Karin recognizes that by repeating and reinforcing connections between the indications of the medication with the safety factors for the patient, she was able to guide the student in learning the action, indications for the medication, and how to administer the medications safely to the patient. In doing so, Karin focuses on ensuring that the student learns how to administer medications safely, a fundamental concept in nursing curricula.

Karin has been teaching in the clinical arena for eight years and seemed to draw upon her teaching experiences and nursing knowledge of paediatrics to guide her in her actions. I found that the more seasoned participants-Nicky, Sally, Jessie, Adele, Keisha, Althea, and Paris, who had taught in the clinical arena for seven to fourteen years-also seemed to draw upon their experiential knowledge of teaching. These participants were able to provide “thick” descriptions of their teaching interventions from their previous teaching experiences. Also, these participants developed their teaching strategies, provided solutions in their teaching based specifically on their teaching experiences and did not solely depend on their nursing experiences to guide their actions. In contrast, participants Margaret, Jackson, and Regina, who had been teaching in the clinical arena for three to eight years, seemed to focus more on their nursing experiences alone to guide their teaching practice.

It appears that experiential knowledge is embedded in teaching practices of competent teachers and develops from integrating many types of knowledge such as experiential, reflective, and formal knowledge of teaching (Connelly, Clandinin & He, 1997; Fenstermacher, 1994; Paterson, 1994). It seems that experiences in teaching alone do not enhance the teaching abilities of educators; rather, formal knowledge of teaching coupled with ongoing and informed reflection guide nurse educators in developing a deeper knowledge of teaching.

Reflection and reflective knowledge.
Participants spoke about the importance of reflecting on their teaching practice and how their reflections helped them with their teaching. First, I explain the definition of reflection that I am using in this study and then describe Althea’s process of reflection on her teaching in the clinical arena.

Reflection is when teachers look back at their teaching and the learning that has occurred in order to recapture and/or reconstruct events and accomplishments in order to improve their teaching. Reflection requires thoughtful consideration and planning so as to engage teachers in planning their activities for their students. Schön (1983) describes two types of reflection: reflection on action and reflection in action. Reflection on action enables teachers to critically examine aspects of their teaching session after the event in order to improve their practice (Schön, 1995), whereas reflection in action occurs while teachers are engaged in teaching. The participants in this study provided a number of examples of reflecting on action. However, only Althea elaborated on her teaching experiences of reflecting in action.

*It’s an ongoing process. I think I reflect throughout the day. When you have an encounter, you talk to the student and you need to reflect about what it means. Am I doing it right? How should I approach this? (Althea, 12-06-2014)*

Althea seems to engage in reflection in action on a regular basis and mentioned how students’ verbal and non-verbal cues guided her in her reflections and interventions. Also, Althea reported that reflecting on her teaching while teaching in the clinical arena as challenging since she had eight students each with varied learning needs and abilities. Althea has been teaching in the clinical arena for over nine years and it seems that reflection in action takes both practice and experience.

In contrasting the reflective process of two participants in particular, Paris and Althea, it appears that Paris engaged in reflection on action whereas Althea used both processes, reflection on and in action. In order to engage in reflection in action, the clinical nurse educator needs to be fully present while engaging in dialogue and learning with students in the clinical arena. Althea seemed comfortable engaging in reflection in action and this suggests her deep knowledge of nursing practice and nine years of teaching experience. Paris had been teaching in the clinical arena for six years and perhaps needed more time to fully develop her teaching abilities.
I found that all participants engaged in reflecting on action on a regular and consistent basis. However, both seasoned and new participants found it difficult to engage in reflecting in action while teaching in the clinical area. Some probable factors could be the multiple needs of student nurses and patients, the myriad and ongoing events in busy nursing units, as well as the complexity surrounding patient care.

In summary, it seems that participants used their knowledge of nursing and teaching concurrently while teaching in the clinical arena. Participants seemed to develop their personal knowledge of teaching by constructing and applying this knowledge to their teaching practice. Participants’ knowledge of teaching included the integration of many forms of knowledge such as formal, situated and embodied, experiential and reflective knowledge of teaching. Furthermore, I found that the more seasoned participants were able to construct and integrate their practical knowledge of teaching quite seamlessly and quickly into their practice.

I contrast the knowledge forms illustrated by participants in this study with results reported by Pauling (2006). In her study, Pauling examined the lived experiences of nurse educators teaching in the clinical arena in Iowa, USA. I briefly describe Pauling’s study and then contrast the study results with those in the current study.

Pauling (2006) conducted a phenomenological study of clinical nurse educators. The purpose of the study was to explore the clinical teaching experiences of nurse educators in order to gain an understanding of clinical teaching. Twenty-four clinical nurse instructors who taught in an undergraduate degree program participated in the study. The investigator used surveys, one group interview, and one observation method to collect data. While all the participants completed the survey, three participants engaged in a group interview process, and one clinical instructor was observed while teaching in the clinical arena. Five themes emerged from the data, but I address one theme in particular as it is relevant to this discussion. The theme “constructing knowledge” was reported as reflecting the participants’ knowledge embedded in their teaching in the clinical arena. This theme is similar to the result found in this study. Even though Pauling’s result was published ten years ago, it seems that most nurse educators are still unaware of the complex knowledge that clinical nurse educators bring to their teaching and they continue to undervalue the contributions of clinical nurse educators. Pauling (2006) also reported “the importance of the clinical nurse educators’ being able to capture these moments to help students place learning within the context of the clinical setting” (p. 80). This quote describes her
participants’ contribution to student learning and is similar to the results found in this current study.

In addition, the results from this current study uncover many more forms of knowledge than those displayed by participants in Pauling’s study. For instance, the results from this study reveal more in-depth details about the participants’ decision-making processes.

6.2. Ethics in Teaching

Participants described many experiences that exemplified their personal and professional values about their teaching. Also, the transcripts revealed many ethical situations that participants encountered on a regular basis while teaching in the clinical arena. The ethical nature of teaching in nursing adds another layer to understanding clinical teaching; and the ethical issues that clinical nurse educators’ encounter and their responses in such situations are largely missing in the nursing literature. In this section, I discuss the ethical values found in the teaching practice of the participants and the values that guided their decisions; their ethical decision making process; discuss the ethical assumptions that underpin a traditional and progressive approach to teaching and its effect on pedagogy and building partnerships with learners; and discuss certain aspects of moral conflict that participants’ encountered while teaching in the clinical arena.

I advance the notion that teaching in nursing is a moral activity and concur with education researchers (Campbell, 2003; Fenstermacher, 2009; Hansen, 1998) whose work in ethics in teaching have guided my understanding. In this section, I discuss five concepts that emerged from the data. They are: participants’ personal and professional values that guided their teaching; the ethical situations that participants encountered while teaching in the clinical arena; ineffective teacher and student partnerships and their effect on learning; the ethical assumptions that underpin traditional and progressive approaches to teaching; and sources of moral conflict found in nursing education literature.

Personal and Professional Values

Study participants mentioned a number of values such as honesty, respect, and fairness that they considered important in their interactions with students, patients, and colleagues. Participants’ personal and professional values seemed to guide them in recognizing the ethical issues inherent in a situation, and influenced their actions while they maintained focus on the needs of patients and students alike. Campbell (2003, 2003a) claims that an ethical teacher
demonstrates values of honesty, integrity, fairness, and compassion in her/his teaching practices and in her/his interactions with students.

The following excerpt illustrates Jessie’s values in her teaching and in her decision making:

_I had another student, and it was a surprise to her to see mom’s bottle-feeding. She’s right, on the benefits of breast-feeding. She [sic-the student] could not understand why they were bottle-feeding. I agreed with her 100% but I said we have to look at the mother’s decision. Whether we agree with it or not, and she [sic-the student] was very surprised about it....I said [to her], “It was very good of you as your role was to educate and to accept the mother’s decision although you did not agree with her in bottle-feeding her baby.” (Jessie, 23-06-2014)_

Here Jessie clearly articulates her values as well as her reasoning for her decision making. In assessing the situation and the student’s response, Jessie was able to discern the ethical issues inherent in the case, and she gently guided the student in examining the salient ethical features of the situation. The student seemed to focus mainly on the benefits of breast-feeding and less on the ethical issues of autonomy of the patient and/or respecting the mother’s decision. Jessie acknowledged the student’s response and guided the student in integrating the professional value of respect in her nursing practice. Jessie’s manner and tone also illustrates her respect for the student and her action denotes the importance of upholding the ethical principle of respecting a student’s autonomy. Also, Jessie demonstrated her values of compassion and empathy for both patient and student in the situation.

Values not only inform a teacher’s moral responsibility to students (Boostrom, 1998; Campbell, 2003, 2003a, 2008; Fenstermacher, 2009; Strom, 1989), students also learn the importance of values through their interaction with teachers. The student nurse in her interaction with Jessie learned the importance of respecting a patient’s wishes and at the same time became aware of her personal beliefs and biases. In this situation, Jessie guided the student in acknowledging her biases, an important aspect of learning.

I was also able to make visible connections between and among the main concepts that emerged from the data. For instance, this excerpt also highlights the intersection of three of the study’s main concepts: _knowledge in action, building partnerships, and ethics in teaching._

Jessie’s action suggests that she had carefully reflected on the many aspects inherent in the situation before making her decision. Reflection _in action_ (Schön, 1983) enables teachers to
carefully consider students’ viewpoints in real time, whilst simultaneously monitoring their personal response while integrating theoretical concepts into their practice. Such fluency in teaching practice takes a considerable amount of experience and expertise. Jessie’s formal preparation in education and her ten years’ experience in teaching enabled her in developing her ethical knowledge of teaching and guided her in her interactions with students.

Jessie also appeared to be very present in her teaching. In being present, teachers are able to ground their observations in many dimensions at once: intellectual, cultural, physical, spiritual, ethical, and emotional (Ayers, 1988). From an ethical perspective, teachers ought to be fully present in their teaching as teaching is simultaneously a moral act and an intellectual challenge. Hansen (1998) explains that teaching is a moral endeavour because the practice involves assisting students to broaden their horizons. It entails helping students to become more knowledgeable rather than less so, more interested in learning and in communicating rather less so, more expansive in their thinking and in their human sympathies. (p. 649)

Jessie, in being present in the situation, was able to discern the ethical issues in that situation and guide the student’s response from an ethical perspective. Jessie guided the student in her moral reasoning and in coming to a decision informed by professional nursing values. In doing so, Jessie contributed to the student’s understanding of integrating important ethical concepts into her nursing practice.

This quote not only describes the moral responsibilities of teachers but also reveals an important ethical assumption. Ethical teaching relies on building a professional relationship between teachers and students. All participants described in detail the importance of building partnerships with their students and frequently mentioned words such as building partnerships, using hope and encouragement and caring in their interviews. These same words were conceptualized and found in two of the study’s core concepts: building partnerships with students and ethics in teaching. Both concepts seem closely intertwined and the effects on student learning is discussed in a subsequent section in this chapter.

I found that different factors influenced newer clinical nurse educator participants in their ethical decision making compared to those more seasoned participants. I found that newer educator participants with six years or less of teaching experience mentioned those professional values outlined by the College of Nurses (CNO), the regulatory body in Ontario, as guiding their teaching decisions. On the other hand, participants with more than ten years of teaching
experience frequently mentioned their commitment to patients and patient safety as the main motivations guiding their decisions. Perhaps not surprisingly these factors that guided seasoned participants in their decisions seem to be more personal and internalized than those mentioned by participants with fewer years of teaching experience.

**Ethical Decision Making in Teaching**

Participants describing the ethical situations that they encountered in their teaching frequently mentioned that they needed to consider and weigh the learning needs of students with the students’ ability to provide safe care to patients. For instance, on instructing students in performing procedures such as administering oxygen to patients, participants described how they needed to carefully consider the learning needs of students, ensure that all students were given the opportunity to meet course objectives, and at the same time consider the implications of their decision on students’ ability to provide safe care to patients. Each factor seemed to add to the complexity of ethical decision making in the clinical arena. Balancing different and sometimes oppositional needs required careful deliberation by participants amidst the busyness found in nursing units. Unlike seasoned participants, I found that participants with five years or less of teaching experience found negotiating this balance difficult and stressful. This result has important implications for nurse educators and nurse administrators in nursing education units and is discussed in the final chapter.

Paton (2005) also describes the ethical knowledge of clinical nurse educators. The results from Paton’s study and this study share similarities in describing the ethical situations that clinical nurse educators encounter and the ethical dimensions found in teaching in the clinical arena.

Paton (2005) conducted a phenomenological study of clinical nurse educators in Alberta, Canada and interviewed nine clinical nurse educators in thirty-two unstructured interviews. She analyzed the data using a Heideggerian interpretive approach and situated the study in “philosophical literature on the notions of tacit knowledge” and practical wisdom (p. 488). The purpose of the study was to explore participants’ experiences of “making sense of situations characterized by a misfit between what is known and what was expected to be known for a given situation, that is *Unready to hand* immersions” (p. 489). Paton explains Heidegger’s concept of unready to hand as the knowledge required to guide a teacher in her/his teaching that does not fit the context and (sic-where) the smoothness of activity is interrupted (p. 493). Clinical educators
portrayed their moral commitment to students and the profession by maintaining respectful relationships with students and doing good for patients. In doing so, participants revealed their ethical knowledge in their teaching and in their interactions with students in the clinical arena in ways similar to those seen in this study.

The ethical dimension to teaching adds another layer of complexity to teaching in the clinical arena. Clinical nurse educators are required to make ethical decisions on a consistent basis. In constructing their ethical knowledge of teaching, clinical nurse educators contribute in significant ways to student learning by modelling ethical concepts within their instruction.

**Ethics in Traditional and Progressive Approaches to Teaching**

Difference in approaches to teaching of nursing emerged as an important finding in this study. In this section, I examine the data using two viewpoints from a participant: her experience as a student nurse and her experience as a nurse educator. The participant’s experience as student nurse reflects a traditional approach to pedagogy and highlights the ethical assumptions that underpin that approach; whereas the same participant’s approach to her teaching reflects a progressive approach to pedagogy and uncovers the ethical suppositions that underpin this approach. I use this participant’s viewpoint of two situations in order to contrast the ethical assumptions that underpin each approach. In the first excerpt, I examine the ethical assumptions that underpin a traditional approach to teaching, and contrast it with the assumptions found in a progressive approach to teaching expressed in the second excerpt.

Keisha spoke about her experience as a student nurse and how it negatively impacted her learning in the clinical arena. It seems Keisha experienced a traditional teacher-centred approach:

*The teacher told me that I would make an awful nurse as I was an awful student and she failed me. I didn’t do anything wrong, I was talking to the nurse about my patient. I went home stressed out. (Keisha, 19-06-2014)*

Keisha did not feel it was safe to speak up because she was afraid of negative consequences affecting her grades. This situation reveals a lack of a respectful relationship between the teacher and the student and reveals how the teacher used a traditional teacher-centred approach in her interaction with the participant.

Other participants echoed similar experiences. In such an approach, the teacher treats students as passive receivers of wisdom rather than as active moral agents (Hansen, 1998).
Hansen (1998) points out that in order for students to be “other than receptacles they must exercise choice and vision toward an end-in-view” (p. 187). Student nurses need to be encouraged to express their ideas and opinions, their values and beliefs so that they can decide for themselves what their particular vision of nursing will be in their transition of becoming a nurse.

Although Keisha experienced a traditional teacher-centred approach as a student nurse, she appeared to adopt a more student-focused approach in her teaching. Keisha emphasized the importance of building relationships with students:

*We are a whole person and not only a nurse. The student is a whole individual not just a nursing student. I love sharing my knowledge, mentoring the younger generation. It is important because they are the future nurses, for us and our families. (Keisha, 05-05-2014)*

It seems that Keisha’s experience as a student nurse enabled her to think more deeply and in a more contextualized way about her teaching. Keisha took courses in teaching and internalized her knowledge of teaching in order to teach differently. Also, it seems that Keisha adopted a constructivist approach in her teaching, an approach where the moral dignity of the student is preserved (Fenstermacher, 2009). As I will show later in this section, when nurse educators adopt a more progressive, constructivist approach in their teaching, their attitude and approach to students becomes more thoughtful and considered.

Hansen (1998) suggests that, in treating students as moral beings, teachers need to enable their students

- of first having an opportunity and competence to say what they think; secondly, desiring to see truly and finding the essential unity of the self and its acts; and thirdly, becoming engaged through perplexity and doubt in a meaningful social outcome. (p. 187)

Hansen suggests that by enabling students to share and discuss their views, students are then able to decide for themselves their decisions and actions. Keisha demonstrates her understanding of the person, the *whole* student nurse thereby illustrating the ethical values that guide her approach to teaching. On examining the transcripts, I found participants with formal preparation in education (Jessie, Adele, Savannah, and Paris) and more seasoned participants (Nicky, Sally, Keisha, Althea, and Karin) appeared to adopt a more progressive approach in their teaching and seemed to be able to articulate the ethics that underpin their teaching more easily.
By contrast, participants with less nursing and teaching experience seemed to follow a more traditional approach in their teaching.

**Ineffective Teacher and Student Partnerships and Its Effect on Learning**

I found that some participants spoke in their interviews about their experiences as nursing students and contrasted these experiences with their experiences as nurse educators. Specifically, participants related these experiences with its negative impact of not building a thoughtful, caring teacher and student partnership. This is an important finding as it illustrates the importance of supportive teacher and student partnerships for effective nursing education.

I found this an interesting paradox since building a nurse-patient partnership is the raison d’être of nursing, yet an explicit valuing of the teacher and student partnership seems to be largely absent in nursing education. Therefore, I think this is an important question for us to consider as nurse educators: How can student nurses learn to care for others when caring is not modelled nor demonstrated by nurse educators in their encounters with students?

I provide two examples to illustrate how participants explained the impact of not building partnerships with their teachers and its effect on their learning. In the first excerpt, Keisha explains this lack of a relationship with her teachers and how it affected her learning:

*I did not feel comfortable. My teachers were very rigid. There were no conversations during conference or during orientation. You bring your syllabus, your assignments and go home. For me learning did not happen there. I did a lot of learning by myself or with my colleagues. I did not feel comfortable. I didn’t feel that it was right. I did not feel connected to my teacher. Learning occurs through connection; effective learning takes place through connection. I always held back information because I was afraid of saying the wrong thing or saying the right thing. I was never sure if I was learning or not. (Keisha, 06-19-2014)*

Keisha explains how not having a strong partnership with her teacher affected her learning and made her question if she was learning. Also, it seems that student nurses were responsible for learning large amounts of content independently. Nursing is understood as a professional discipline with its own particular language, knowledge, and skills. Therefore, another important question arises: How can student nurses learn the language, knowledge, and skills of nursing without explanation, guidance, and support from their nurse educators?

Similar to Keisha, other participants also mentioned the lack of teacher-student partnerships in their student journey and its negative effect on their learning. To date, the negative effects arising from a lack of respectful and supportive partnerships between teacher
and student has not been examined in the nursing education literature, and yet one could argue that building a respectful teacher-student partnership in nursing education is equally, if not more important as building the teacher-student partnership so valued in the teacher education literature (Boostrom, 1998; Hansen, 1998).

In the second excerpt, Adele, who completed a graduate program in nursing and education, contrasts her learning in each of her graduate programs. In the excerpt, Adele focuses on the “how” of teaching and the “how of building partnerships” that guided her learning:

> I created my own learning environment. The learning was not happening in the class [sic-nursing]. It was mostly outside of the classroom setting. I did the assigned readings, papers to submit, I did really well in that part. But learning was outside of the classroom....People being able to talk to you, to meet with you, to guide you. I think it makes a huge difference. Being open to ideas, being open to different thinking styles. Whereas when you go to [a graduate program in nursing], you are not seen as equal, that’s how it feels. You are just here to complete the course work and go to the workforce and be a nurse.

(Adele, 12-05-2014)

It appears that the manner and the openness of the teacher to new ideas that Adele encountered in her program in education facilitated her learning beyond that obtained through merely delivering content. Also, the manner and attitudes displayed by the teachers in their interactions with students reflect teaching values.

From these excerpts it seems that neither participant received ethical guidance in their encounters with their nurse educators. Boostrom (1998) and Hansen (1998) add that teaching is premised on guiding and enabling students in their intellectual and moral development as human beings. It seems that the lack of ethical guidance reflects the lack of knowledge and understanding of those ethical aspects that one could argue ought to underpin one’s teaching of nursing.

Although, both Keisha and Adele mentioned the difficulties that they encountered as student nurses, both participants learned the importance of building partnerships with students from their reflections and experiences as nursing students. Often, participants mentioned that building partnerships with students was a rewarding and gratifying experience. They also mentioned the importance of creating an atmosphere and creating opportunities for students to express themselves. By relinquishing their sole claim on authority, the participants encouraged student nurses to develop their individual moral agency.
Participants and Moral Conflict

I describe the constraints that participants encountered and how they negotiated around the constraints to fulfil their ethical obligations to student learning and safe patient care. It seems that most participants encountered moral conflict mainly when instructing students on how to safely administer medication.

In the excerpt below, Margaret indicates the many variables that she needed to consider when instructing students to administer medications. The excerpt also highlights the divergent and competing variables that Margaret had to consider in making her decision:

*Having eight students is a lot. When you are starting to do medication and watch them do medication, it is a lot. I think that’s the biggest disadvantage to clinical teaching compared to teaching in the classroom, I would say. You want to give each student a good chunk of your time and when you have eight students giving medications and all are due at 10 am, you really can’t. [Especially] if one student takes half an hour [and] you have seven [other] students who have to give meds by 10 am. (Margaret, 27-06-2014)*

The excerpt illustrates the stress that Margaret experienced when instructing students in administering medications. Margaret explains that she needed to consider the individual student’s learning needs, the learning needs of all students in the group, the patients, and the unit’s policies. The excerpt reveals the ethical conflict that Margaret experienced as she tried to fulfill conflicting and divergent obligations to each student and to the patients for whom the students provide care. Also, Margaret needs to meet requirements in the curriculum that determine when students should begin to administer medication and at the same time negotiate her ethical responsibilities as a nurse educator to student learning and safe patient care. In addition, student nurses may not have had adequate knowledge in the administration of medications, yet the curriculum prescribes when student nurses should administer medications. All these factors add to the conflict that Margaret experiences and which she needs to resolve in an ethical manner for students and patients alike. Similarly, all participants expressed a number of occasions where they experienced ethical conflict while teaching in the clinical area.

I found that both new and seasoned clinical nurse educator participants struggled with making appropriate ethical decisions and it seems that tensions between the prescribed curriculum and clinical imperatives were the main source of moral conflicts. Participants also mentioned the lack of opportunity to share and discuss their problems with other clinical nurse educators, the lack of adequate preparation and the lack of support as contributing factors. These
factors seem to add to the complexity surrounding teaching and ethical decision making in the clinical area.

This result echoes similar concerns expressed by other nurse educators. For instance, Dinkelman, Margolis, and Sikkenga (2006) and Kopala (1994) state that clinical nurse educators have additional responsibilities compared to nurse educators teaching in the classroom. Clinical nurse educators have competing responsibilities as they are directly responsible to students, to patients for whom the students provide care, to the educational institution, to hospital organizations where the clinical instructor operates, to their professional expectations, and to school-practice partnerships (Kopala, 1994).

Stokes (2007) found that nurse educators experience moral conflicts in teaching nursing students in the health care environment as result of their obligation to those patients for whom the nursing students provide care, commitment to the students they educate, and to the education institutions in which they work.

Stokes (2007) also reports that clinical nurse educators in particular encounter moral conflicts in relation to failing a student nurse in the clinical arena. The source of this tension stems chiefly from the need to apply two opposing philosophical perspectives of justice and care. The assumptions that underpin each philosophical approach direct a nurse educator’s understanding and approach in a given situation. For instance, the approach used by most educational institutions in relation to student’s success in academia is premised on an ethic of justice. In an ethic of justice approach, principles such as fairness, equity, and rational deliberation are paramount. The education institution focuses on quantifiable measures and objective assessment in making its decisions as its focus is to protect and promote the well-being of the student. Nurse educators teaching in the classroom, which is a less complex teaching context, tend to use an approach premised on justice. By contrast, most clinical nurse educators tend to chiefly use an ethic of care approach in their judgment (Stokes, 2007). An ethic of care approach focuses on responsiveness, attentiveness, and the contextual nature of the situation. The clinical nurse educator has a close relationship with students in the clinical arena and the life-and-death aspect of patient care in the nursing context may emphasize the significance of the ethics of care perspective. Clinical nurse educators tend to focus on both the patient and student simultaneously and thus use both the justice and the care approach in varying degrees. Balancing when and how to use each approach is difficult for seasoned and new clinical nurse educators.
alike. Also, the lack of opportunities for participants to share and learn from, by discussing ethical situations related to their teaching with other nurse educators adds another aspect to the difficulties that participants experienced in their teaching.

In summary, I concur with those education researchers (Campbell, 2003; Hansen, 1998; and Strom, 1989) who argue that teaching is a moral activity. Teaching in the clinical arena in nursing is a complex activity, and I found that both new and seasoned clinical nurse educator participants struggled in making judicious ethical decisions as they considered students’ and patients’ concerns simultaneously.

6.3. Varied Approaches to Teaching

In the results section, I described a divide amongst nurse educators that emerged from the data and this includes nurse educators who taught mainly in the classroom and clinical nurse instructors. Nurse educators teaching in the classroom seemed to set the curriculum including clinical learning activities such as when students administer medications and clinical nurse educators that were tasked to implement the curriculum. In this section, I explain in detail that clinical nurse educator participants seemed to adopt a progressive approach to curriculum development, instruction, and building a teacher and student partnership compared to nurse educators teaching in the classroom. It seems that nurse educators teaching in the classroom tended to adopt a traditional approach to curricular development and pedagogy. My purpose in contrasting the two approaches is to conceptualize how each approach influences pedagogy and impacts student learning. I first explain a traditional Tylerian approach to curriculum and pedagogy followed by a re-constructivist approach using a critical pedagogical stance.

One of the most cited authors of the traditional approach to education is Ralph Tyler (1969) and in the “Literature” section, I introduced and described the work of Tyler. I now further address Tyler’s work in describing the teaching practice of nurse educators in the classroom. I contrast the traditional approach used mostly by nurse educators teaching in the classroom as described by participants with the progressive approach displayed by participants. Specifically, I utilize the theoretical framework forwarded by Giroux, Penna, and Pinar (1981) to situate my argument because these authors examine teaching using a critical pedagogical stance that enabled me to explain, in more depth, the limitations and affordances for the various approaches to teaching. I briefly describe important features of the framework and then provide excerpts from the transcripts to situate my position.
Giroux, Penna, and Pinar’s (1981) theoretical framework situates curriculum development, teaching, and instruction using three perspectives: traditional, conceptual-empirical, and re-conceptualist. Each approach highlights particular viewpoints in conceptualizing knowledge, curriculum development, instruction, and the teacher and student partnership. Also, each approach is characterized as having dominant and subordinate assumptions that govern knowledge and values found in each respective lens (p. 13). I focus on two perspectives: traditional and re-conceptualist, as both are germane to results that emerged from the data. The traditional approach enables me to conceptualize the teaching practice of classroom nurse educators as described by the participants; the re-conceptualist approach lends itself to explaining the teaching practices of the participants.

Giroux, Penna, and Pinar (1981) situate certain authors in each approach. In describing traditionalists, the authors focus on the work of few education theorists such as Tyler, Taba, Bobbitt, and Klein. In this discussion, I focus on the work of Tyler (1969) to illustrate the elements of a traditionalist lens.

**Impact of Tyler’s Approach in Undergraduate Nursing Curricula**

I utilize participants’ experiences of instructing students with medication administration in the clinical arena as illustrations for my discussion. Nurse educators teaching in the classroom are mostly involved in developing and designing curricular content, including when and how medication administration is taught in the curriculum. The sequencing and timing of medication administration in undergraduate nursing curricula described by participants is an example of a Tylerian approach to curriculum with its emphasis on control in completing tasks.

Safe administration of medications emerged as an important issue as it was mentioned by nine of the twelve study participants and is also an important concept in the nursing curriculum. In the following excerpt, Sally describes problems with teaching students how to administer drugs:

*They are taught how the drugs work and not how to look and decide when to give the medication and what you are going to follow up with it. For example, furosemide—why is the client on it? And how are you going to tell the client what the purpose is? And what are you going to have ready at the bedside as the client will be voiding a lot after two hours?...It probably is a good example of it being decontextualized and it’s my role to ask every student what is the purpose of this medication. (Sally, 28-06-2014)*
Sally identifies a number of problems that she encountered on instructing student nurses on how to administer medications in a safe manner in the clinical arena. She mentions how both students’ lack of knowledge of the medications and lack of knowledge related to safe administration of medication procedures seems to be under-emphasized in the classroom. In addition, teaching about medications is typically presented in a decontextualized way in the nursing curriculum. Furthermore, the point at which medication administration is actually taught in the prescribed curriculum is focused solely on the tasks and not on the importance of linking that knowledge to the patients that students encounter in practice. Consequently, there is less focus on significant elements such as the level of students’ applied knowledge and understanding related to the task. Medicine administration is included right at the time that student nurses are still learning to build relationships with patients and provide essential nursing care; important concepts in undergraduate nursing curricula, and ones that arguably student nurses should possess before learning medication administration. Building relationships and honing one’s knowledge of assessment of a patient are foundational components for safe and effective medicine administration processes.

This traditional view of curriculum emphasizes efficiency instead of understanding and focuses on information that can be directly transmitted to students. With a Tylerian lens, possession of information equates to understanding and application of that knowledge, and thus does not take into account the context or complexity of the learning involved in administering medications in a safe manner.

Sally also mentions the importance of instructing each of her eight students about the medications that each student administers. This instruction needs to occur in a much more student-focused and time-sensitive manner. I found that the inadequate preparation of student nurses in the application of that knowledge and the high instructor-student ratio had a negative impact on participants’ teaching practices.

In a Tylerian approach to curriculum, the educators’ thinking is guided by what Giroux, Penna, and Pinar (1981) term “technocratic rationality” (p. 99), where the main purpose of a teacher’s knowledge is to complete tasks efficiently. Here, the teacher’s focuses on carefully preselecting objectives and sequencing learning experiences in order for learning to occur. The teacher focuses on observing and monitoring changes in behaviour in order to maximize productivity. Students’ ability to deeply understand and/or integrate the information in their
nursing practice and the implications of administering medication to patients in a safe manner is not considered in a traditional Tylerian approach to learning. Although, there is some evidence that suggests that direct instruction is an appropriate means of providing factual content that “there is less evidence that this instruction transfers to higher order cognitive skills such as reasoning or problem-solving” (Daniels, Lauder & Port, 2009. p. 32), nor does direct instruction afford learners the flexibility to use and transfer that knowledge to new contexts and situations.

Participants described this curriculum as rigid and unable to capture the complexity found in actual nursing practice that student nurses consistently encounter. It seems that how this curriculum was conceptualized, the types of information included, and the evaluative measures used reflect a mechanistic, reductionist form of training consistent with how instruction was typically viewed at the time Tyler’s ideas were first enthusiastically embraced. Kincheloe (2008) taking a critical pedagogical approach, coined the acronym FIDUROD (p. 22) to describe this mechanistic approach to curriculum development. The acronym stands for a “formal, intractable, decontextualized, universalistic, reductionist and one dimensional” (p. 22) approach to curricula. In this approach, knowledge is conceptualized as external and where truth is viewed as needing to be deposited in student minds. The diverse ways of knowing and contextual factors that influence learning and the learner are largely ignored or dismissed. This reductionist focus in the curriculum does not enable students to develop their knowledge of nursing, transfer their knowledge to new situations nor does it enable clinical nurse educators to guide students in developing their knowledge or enable nurse instructors to develop their pedagogical knowledge, an important aspect in the scholarship of teaching in nursing education.

Although participants varied in years of teaching experience, they all experienced stress and unease when instructing students with medication administration, suggesting that this problem continues even with seasoned clinical nurse educators. The processes involved in overseeing safe medication administration are complex. Specifically, a clinical nurse educator needs to assess a student’s knowledge of each medication, assess each student’s knowledge in a clinical group of eight students, and observe as each student administers medications to her/his patient, all in a timely manner. Further, any patient may have many medications to be administered all at the same time, all of which have different indications and potential interactions. Finally, medication administration is only one task out of a myriad of tasks that nursing students perform on a daily basis, and clinical nurse educators instruct and guide
students with a number of such learning activities over any given shift, indicating the considerable challenges of coordinating their teaching time and focus.

It seems that nurse educators involved in developing the curricula seemed to focus on the task, the specific skill associated with drug administration (i.e., how to administer or inject the drug), whereas participants in this study seemed chiefly concerned with student learning and with each students’ ability to administer medications safely to patients. This difference in approach between clinical nurse educator participants and nurse educators teaching in the classroom reflects a re-conceptualist understanding of learning. Nurse educators in the classroom tend to use a lecture format more frequently (Diekelmann, 1990, 2001; Diekelmann & Smythe, 2004; Ironside, 2001, 2003) than focus on individual student learning needs. Also, this result indicates that clinical nurse instructors possessed a deeper, more nuanced and progressive understanding of safe patient care than nurse educators teaching in the classroom.

Participants also reported that student nurses did not possess decision-making abilities to administer medications to patients in a safe manner. They reported that students did not necessarily possess the broader clinical skills such as adequate assessment knowledge of their patients and therefore could not fully understand the implications and/or consequences of administering the prescribed medications to patients. Furthermore, teaching in the clinical arena seems complex as participants need to consider many variables, and such complexity of decision making does not lend itself to a linear or simple hierarchic view of curricular knowledge. Instead, the data suggest that participants have to take maximum advantage of whatever clinical situation presents itself and use that to positively affect student learning, a more progressive approach to teaching the curriculum.

I found that six of the twelve participants (Jessie, Adele, Keisha, Savannah, Althea, and Margaret) taught in more than one school of nursing, ten taught in more than one undergraduate nursing program, and five taught in accelerated undergraduate nursing programs. Yet, despite these diverse locations, all these participants reported similar concerns with the timing of medication administration in the curriculum, highlighting the pervasiveness of a Tylerian approach to undergraduate nursing curricula in nursing. Conventional pedagogy, which is “the predominant pedagogy used in nursing education, emphasizes cognitive gain and the efficient and effective provision of information to students” (Kliebard, 1987, as cited in Ironside, 2004, p.
6), as opposed to progressive approaches to pedagogy that emphasize construction of knowledge in facilitating understanding.

The results in this study indicate that nurse educators teaching in the classroom tend to use a traditional approach in building curricula and in their teaching practice. This result adds to existing literature in nursing education that found that a traditional approach is the predominant model used in nursing generally (Diekelmann, 1990, 2001; Ironside, 2001, 2004, 2005a, 2015; McAllister, 2005a, 2005b; Mitchell, Jonas, & Cross, 2012; Tanner, 2007a; Walker, 2005, 2009).

An important assumption that underpins traditional pedagogy is the role of the teacher and student and where the teacher controls the learning process and the student’s role is to demonstrate her/his knowledge on preselected objectives within a pre-specified time frame (Giroux et al., 1981). However, there are serious implications of having such a rigid pedagogy that is separated from the context in which it is practiced.

Another important feature of a traditional approach to learning is the use of quizzes and exams in which students must demonstrate their knowledge on preselected course objectives. Student nurses’ knowledge is most frequently assessed by the use of quizzes or multiple-choice question formats. Ironside (2005b) and Young and Diekelmann (2002) note that the widespread use of multiple-choice exams as the chief method of evaluation in undergraduate nursing curriculum is problematic given that student nurses need to perform at a much higher cognitive level when they are assessing patients and making integrated decisions in their clinical practice.

Masters et al. (2001) studied the use of multiple-choice questions in nursing education and found that most test questions were written at the knowledge level, which depends on memorization and recall of content while only 6.5% were written at the analysis level (p. 25). It seems that memorization and recall remain central to nursing exams despite the increasing amount and complexity of information and the complex situations that student nurses encounter in practice; each factor adds to the multilevel decision making by student nurses in the clinical arena. As I show a bit later in this section, teachers who adopt progressive methods of evaluation such as reflective journaling not only encourage students to think more deeply and broadly about issues but also enable students to integrate this knowledge in their practice and reflect on their learning process.

Adding to the problems found in the evaluation methods in a traditional approach are the number of flaws in the writing of questions for multiple-choice exams that have been identified.
in nursing education (Tarrant, Knierim, Hayes, & Ware, 2006; Tarrant & Ware, 2008). Most nursing faculty do not have the necessary knowledge or the time to write high-quality test questions that would be able to address more integrative and complex aspects of knowledge that students should possess in order to make decisions about the care they provide to patients.

**Impact of Tyler’s approach on instruction in nursing education.**

Study data revealed that student nurses were taught the theory of medication administration in the classroom using a lecture format. However, because the content associated with medication administration is substantial and complex, this method of instruction has serious limitations. It appears that classroom instruction focused mainly on providing information to students and not on students’ understanding of content or on students’ thinking associated with safe medication administration or the consequences to patients when errors are made.

In using Tyler’s instructional approach, the teacher is considered to be the expert and this stance lends itself to a transmission form of instruction. Efficiency and expediency of providing large amounts of information within a short time frame remains the focus. Additionally, the teacher’s prescribed meaning to a given context is considered the only valid form of knowledge. The students’ construction of knowledge related to administering medications in a safe manner is ignored in this approach.

For instance, Nicky points out concerns about teaching about medication too quickly:

*I have colleagues who insist that students need to be giving medication right away and as soon as possible, etc. I have worked very hard to stay true to what feels right to me in that regard. In fact, I did have a very serious near-miss medication error. Thank goodness, we did not deliver the medication. It was insulin. It was one of the worst days of my life ever. It was six years ago but it seems like yesterday. It is exactly because of all the complexity in medication administration that it is very important to engage in a process that introduces them to that safely and slowly so that I can have the utmost confidence that the student is prepared to perform that skill. (Nicky, 12-06-2014)*

Nicky indicates her ongoing concerns about when student nurses should begin to administer medications. She states that she tries to ensure that each student possesses adequate knowledge of the patient’s condition and the prescribed medication so that each student is able to administer medications in a safe manner.

Nicky is in a unique situation because she teaches in the classroom and clinical arena and seems to have more influence on the curriculum. Unlike the remaining eleven participants, Nicky
seemed to be the only participant not to have raised concerns with the lack of input into curricular decisions. Most participants seemed to be left in a conflicted situation: either to follow the prescribed medication administration time frame in the curriculum or take a risk and delay students actually administering medications until they demonstrate adequate knowledge of both the medications and the patients. Although participants acknowledged that student nurses develop knowledge of their patients at different times in different ways, participants were advised to follow the prescribed curriculum. I describe participants’ experiences with the problems they encountered with the prescribed curriculum in more depth in the next section, “The Context.”

Additionally, participants seemed to possess a deeper and more sophisticated understanding of patient safety and student understanding of safe patient care than nurse educators teaching in the classroom and setting the curricula. Participants’ understanding of patient safety concepts in their teaching emerged as an important finding from the data. Participants seemed to use a more contextualized and individualized approach in their teaching. For instance, participant Althea mentioned teaching strategies that she utilized to guide her decision making related to when student nurses administer medications. Althea stated that she built on students’ previous knowledge and experience in nursing to guide her decisions.

I found that participants with formal knowledge of curriculum and teaching (Jessie, Adele, Savannah, and Paris) were able to strategize more quickly and tailor their teaching in order to ensure that students learned in more depth the important safety aspects surrounding medication administration; whereas participants with three to five years of teaching experience alone (Margaret, Jackson, and Regina) seemed to learn through trial and error. Ironside (2004) adds that a conventional approach to instruction in nursing has led nurse educators to focus on “what students need to learn to practice while little attention is given to how students learn to think about evolving and complex practice environments” (p. 6). This recommendation is important for nurse educators to consider whether they should change their focus on delivering content to focus more on understanding how students think about the content. Overall, it seems that participants with formal knowledge of curricula and pedagogy and teaching experience of more than six years were better able to instruct students more effectively in their learning.

Young and Diekelmann (2002) found lecturing to be the most common and predominant form of teaching in most undergraduate nursing programs as it is an efficient way to convey
large amounts of content to students within a short time frame. Similarly, Benner et al. (2010) have noted that most nurse educators teaching in the classroom tend to focus on pre-specified PowerPoint presentations and do not tailor their teaching to meet students’ learning needs. Nurse educators’ lack of formal knowledge of teaching, curriculum development, and knowledge about their learners are the most common factors that influence the teaching practice of nursing educators.

I introduce results from a study conducted by McKenna (2004) who studied the teaching practice of clinical nurse educators in Australia. I found that McKenna’s explanation adds another perspective to understanding the negative impact of using only nursing knowledge to develop nursing curricula and pedagogy. The result offers some interesting insights about the thinking process that guides nurse educators in developing curricula.

McKenna (2004) conducted a qualitative study in Australia using a Foucauldian approach. The author interviewed nine clinical nurse educators. The purpose of the study was to explore the types of discourses that impacted the work of clinical nurse educator participants. Although the study results revealed a number of important findings, I focus on one result that is germane to the results of this study. She found that the influence of disciplinary nursing discourse versus an education discourse was greater in developing undergraduate nursing curricula and teaching. McKenna explained that “disciplinary time according to Foucault (1977) involves organizing learning time into segments and stages, with each having their own qualifying processes allowing students to progress onto the following stage” (p. 199). The purpose of timetables is to “impose structure and discipline the learning process” (p. 199). In other words, completion of tasks within a predetermined time frame controls what, when, and how students’ learn in undergraduate nursing curricula and illustrates a traditional Tylerain approach towards learning and knowledge. This can be contrasted with clinical nurse educators using a constructivist lens that enables them to guide each student in her/his development, understanding, and guiding students in their transition into becoming a nurse. I find McKenna’s explanation helpful as it further elaborates the divergence between traditional and more progressive approaches to teaching and learning in nursing education. In addition, and similar to, the results found in this study, McKenna found that her participants experienced significant tension in implementing the prescribed curriculum.
The traditional Tylerian approach to nursing education seems less suited to today’s learner; perhaps in the early 1950’s when Tyler introduced his theory, students could have struggled to access information. However, today most students are able to find current and relevant information quite easily. The results from this study indicate that student nurses need more guidance and assistance with understanding the implications of specific information in order to develop their knowledge of nursing and how to care for patients. Therefore, continuing to use a traditional approach to curricular development and pedagogy in nursing education needs to be scrutinized. Furthermore, not all undergraduate nursing curricula seem to be either relevant or useful in guiding student nurses in their practice and the selection of content needs to be examined in a more critical manner. It seems that although the disciplinary knowledge of nursing has evolved and matured over time, the knowledge that nurse educators use to guide them in developing curricula and pedagogy has not.

**Impact of Tyler’s approach on a teacher and student partnership.**

In this study, I focused exclusively on clinical nurse educators and on their perspectives of the teacher and student relationship. Participants’ experiences as student nurses and the impact these experiences had on their learning emerged to form the sub-concept of *Unlearning in order to teach*. On exploring teacher and student relationships with participants, I found a sharp contrast between participants’ experiences as student nurses and their experiences as clinical nurse educators with their students.

In this section, I re-examine an excerpt provided earlier to illustrate how certain concepts such as “Building partnership” and “Approach to teaching” are interwoven and provide an example of multiple coding strategies used in analyzing the data. The varied coding strategies used in this study are detailed in the “Methods” section of this thesis.

In the excerpt below, Adele contrasts her student experiences in her graduate programs in nursing and education.

*I created my own learning environment. The learning was not happening in the classroom [sic-nursing]. It was mostly outside of the classroom setting, I did the assigned readings, papers to submit, I did really well in that part. But learning was outside of the classroom....People being able to talk to you [sic-education], to meet with you, to guide you. I think it makes a huge difference. Being open to ideas, being open to different thinking styles. (Adele, 12-05-2014)*

164
Adele was the only participant who had recently completed graduate studies in both nursing and education. She contrasted her experiences in each program and described the impact of each program on her learning. Adele reports that in her graduate program in nursing, she did not have a partnership with her nursing faculty, whereas in her graduate studies in education, she learned the importance of developing a professional relationship with her students based on her own learning with professors in education. Her graduate program in nursing had a traditional approach to a teacher-student partnership whereas her graduate program in education took a progressive approach to the teacher-student partnership that had a lasting and positive impact on her teaching.

A few participants also described their relationship with their nurse educators as hierarchal and authoritarian in nature. Participants reported that they needed to unlearn in order not to perpetuate this form of relationship with their students. The process of unlearning as described by Jan Tyler (2011) is detailed in the “Results” chapter. In a Tylerian approach, the teacher’s position as a knowledge expert defines the teacher and student relationship. The relationship is hierarchical in nature and students adopt a submissive, acquiescent manner. The teacher initiates the conversation since the focus is on providing information and not on “shared communication or understanding” (Giroux as cited in Giroux et al., 1981, p. 101).

Adele seemed to adopt a more progressive approach to her teaching and in her encounters with students. For instance, she states:

*For my students, it is a more holistic approach; it is not just here and now. But what else do you know; some students really shine when you ask other things they can prove that they know. Things that they don’t know, they can search and find. As you let them do it, they go one step more.* (Adele, 11-08-2014)

Adele confirms that she focused on building a beneficial nurturing partnership with all her students. She stated that building partnerships took time as she learned to navigate the boundaries of a teacher and student partnership. Maintaining professional boundaries emerged as another sub-concept and is detailed in the previous chapter.

In summary, the traditional approach to curriculum development, instruction, and building partnerships, does not benefit students in their learning or teachers in their teaching as much as a more progressive approach, but instead appears to create painful experiences for both teachers and students.
Participants’ use of a Re-conceptualist Approach

I suggest that participants’ teaching actions reveal a re-conceptualist perspective, particularly in their understanding of curriculum, pedagogy and in building partnership with students. Therefore, I integrate and elaborate certain aspects of a social constructivist and critical pedagogical approach described in the “Literature” chapter.

Constructivists support the idea that individuals are purposeful learners and that students' construct knowledge in their interaction with others or with their environment in order to make sense of the situation and in doing so create meaning for her/himself (Driver, Asoko, et.al. 1994; Driver & Oldham, 1986; Phillips, 1995). The learner engages in listening, interacting, responding to the situation and in doing so, constructs her/his meaning of the experience; construction of meaning is understood as a “dynamic process where the learner generates hypothetical meanings and checks these meanings for fit in the situation” (Driver & Oldham, 1986. p. 110).

Constructivism evolved over time and has influenced many approaches including a re-conceptualist approach to pedagogy. As this approach further evolved, re-conceptualists integrated features from critical pedagogy and this lens takes an active political stance with emphasis on how power relations are reproduced in our daily structures and institutional processes. The results from this study reveal an imbalance of power between and amongst nurse educators and using the re-conceptualist lens has enabled me in conceptualizing the results more completely. In the section below, I provide excerpts and conceptualize each using a re-conceptualist lens as it relates to instruction, curriculum development, and the teacher-student partnership.

Education scholars have commented expansively on teaching from a critical theoretical perspective and include Giroux, Penna, and Pinar (1981) and Freire (1998). I focus chiefly on the work of these education scholars in this discussion as their ideas seem most relevant to the results.

Participants approach to instruction using a re-conceptualist lens.

Participants’ acknowledged that student nurses bring knowledge to their learning and emphasized the importance of building on a student’s previous knowledge and experience as important considerations influencing their teaching. Also, participants provided space and opportunity for students to showcase their knowledge. I provide two excerpts to illustrate
participants’ use of a re-conceptualist approach in their teaching. Nicky acknowledges how she addressed her students:

I say to each of you, you are unique. So please don’t ever feel that you have to do it like someone else...you have all your life experiences that you bring to the patient’s moment, you have all that you are and nobody else is who you are and nobody could bring what you could bring to the interaction. (Nicky, 06-05-2014)

Nicky recognized the uniqueness of each student, and the varied forms of knowledge and experiences that each student nurse brought to their nursing practice. Nicky has taught for over fourteen years and used her experiences to guide her teaching.

Similarly, seasoned participants described their teaching experiences where they enabled student nurses to showcase their knowledge and accomplishments. Giroux states that “knowledge is not simply about an external reality; it is more importantly self-knowledge, oriented toward critical understanding and emancipation” (Giroux as cited in Giroux et al., 1981, p. 101). These authors focus on the interrelationship between the learner and knowledge, the knower and the known, where the purpose of learning is to improve understanding of the content and/or the issue. Using this concept of knowledge, a student’s ability to generate personal knowledge of context and content supports the individual’s personal growth to accomplish goals, to transfer learning to varied situations and contributes to development as a nurse and a citizen in society.

In the following excerpt, Althea states that she tailors her teaching in order to meet the learning needs of each student in her clinical group. She focuses on guiding students’ in developing their ability to critically think and raise questions about the care that they provide to patients.

From an educator perspective I am thinking about you (the student). How are you going to care for this patient? In what ways should I teach you so as to maximise your knowledge to help you so that you can better care for this patient. The educator has to look at more perspectives about how to develop the student than a nurse at the bedside. As a bedside nurse, you have a smaller perspective as you are focusing on your own day, your shift and your patient assignment. As an educator you have to look at the bigger picture... An educator has to look at the bigger picture because you are teaching somebody to become a nurse. In order for them to become a nurse it is a lot more that being task oriented. You need to develop student’s critical thinking... The nurse educator role is very complex. The ways of teaching is complex as a nurse educator. You have to know what you need to do to make it safe for your students to learn. (Althea, 12-06-2014)
Althea explained how she tailored her teaching so as guide each student in their understanding of becoming a nurse. She focused on developing each the students’ ability to generate their personal knowledge of nursing and in doing so demonstrates a progressive approach in her teaching. Althea has taught in the clinical arena for approximately nine years and used her experiential and reflective knowledge of teaching to guide her practice. In a constructivist approach to instruction, the teacher elicits the prior knowledge of the topic being taught in order to construct new knowledge. Also, students were introduced into understanding the new modes of reasoning in order to construct the cognitive structures required to understand that new knowledge rather than the content itself (Bächtold, 2013).

Althea also identified some important elements in becoming a nurse educator. She stated that a nurse educator needs more in-depth knowledge of nursing and patient care so as to guide students. She stated that as a nurse educator she used varied forms of knowledge in a given situation. Participant Jackson further detailed the many sources of information that a nurse educator draws upon in order to guide her teaching practice.

Participants, by adopting a progressive approach in their teaching, enabled student nurses to generate their personal understanding of nursing and their contribution to patient care. I found that participants with formal knowledge of education (Jessie, Adele, Savannah, and Paris) and participants with more than seven years of teaching and nursing experience (Nicky, Sally, Keisha, and Althea) used a re-conceptualist approach frequently in their teaching. These participants adopted a more individual and student-centred approach in their teaching and built on individual student’s strengths and abilities and were able to guide the students in their understanding of what was required to become a nurse.

Reflection emerged as an important factor in enabling participants to adopt a progressive way of teaching. Reflection is considered integral in becoming aware of one’s assumptions as it enables a teacher to go beyond the performative aspects of teaching and instead focus on the teacher’s values, influences, and biases (Giroux et al., 1981). Giroux et al. (1981) argue that teachers need to be encouraged to engage in reflection in and about their teaching practice:

If teachers do not bracket their own basic assumptions about curriculum and pedagogy, they do more than transmit unquestioned attitudes, norms and beliefs. They unknowingly may end up endorsing forms of cognitive and dispositional development that strengthen rather than challenge existing forms of institutional oppression….To ignore this important notion is to relinquish the possibility for students and teachers alike to shape reality in an image other than the one that is
socially prescribed and institutionally legitimated. (p. 104)

Bracketing enables educators to become aware of their own biases and assumptions, and allows them to separate personal opinions from the external reality of the situation. Self-reflection enables clinical nurse educators to examine and explore assumptions and beliefs related to teaching and learning and to acknowledge factors that could influence their interpretation of the situation. Participants spoke eloquently about the depth and frequency of engaging in reflective practice in their teaching both in the clinical arena, and at the end of the teaching day. As participants became aware of their own values and assumptions, they were able to acknowledge and address those in their teaching.

**Participants approach to curriculum using a re-conceptualist lens.**

The results reveal that although participants were not involved in decisions related to developing the curriculum, their comments and suggestions indicate a progressive approach to curricula development, design and implementation. In the following excerpt, Margaret shares her concerns about the teaching of medication administration in the prescribed curriculum and suggests a more progressive approach:

*I think there is a greater risk if I allow students to give medications in week two and they are not prepared. When I do medication for the first time, it takes me half hour per student. Throwing that [medications] into the mix in the second week, I don’t feel comfortable doing that. I feel I need to build my students up by doing a proper assessment. In medication administration, I will take that risk and wait until they are ready and able to do it. This will be the first time that they will go through the process of looking up medication, getting the meds, doing the rights. I think it is extremely important that they go through the process each and every step correctly and that they understand the importance of each step. I think in order to do that it takes time. I need them to go through all of the rights with me. I like to spend time with them, make sure what they are giving, why are they giving it, why is their patient getting it, how it’s going to affect their patient before I can let them give meds. It’s about patient safety; it comes down to patient safety. (Margaret, 27-06-2014)*

This excerpt reveals tension between the participants knowing when student nurses should administer medications and the timelines found in the prescribed curriculum. While some participants delayed the timing of medication administration in order to ensure that students had an understanding of medications, other participants adapted their teaching to meet students and curricular demands. This process of adapting and/or adjusting reflects how the participants
understood the challenges they encountered and the negotiations between meeting curriculum objectives, students learning, and patient care. Furthermore, in examining adaptation processes using grounded methodology, investigators can create a theory from the data (Corbin & Strauss, 2015).

Participants provided their rationale for the level of knowledge and kinds of experience that students need to develop so as to be safe and effective at administering medications, thereby demonstrating their knowledge of developing curricula. Furthermore, participants guided students in developing their cognitive abilities for instance, in developing particular forms of critical thinking and reasoning to administer medications and this kind of construction of knowledge corresponds to distinct facets of learning science where “understanding and mastering new models of theories which are made explicit and communicable by means of symbols…acquiring the necessary cognitive structures (the necessary concepts and modes of reasoning) for mastering these models or theories” (Bächtold, 2013. p. 2482), and where teachers guide learners in building these new cognitive structures and reorganizing their old ones.

Participants seemed to use a re-conceptualist approach to curriculum development where curriculum is understood not merely as an object or a product:

It becomes a verb, an action, a social practice, a private meaning and a public hope. Curriculum is not just the site of our labor; it becomes the product of our labor, changing as we are changed by it. It is an ongoing if complicated conversation. (Pinar, 2004. p. 188)

Using a re-conceptualist approach, curriculum is understood as a dynamic, intersubjective, and intrapersonal conversation where the teacher engages in ongoing self-reflection and discussion with students and others. Participants provided their views on selection and sequencing of content and choosing content that aligned with their students’ clinical experiences, particularly in relation to medication administration. They advised that medication administration should be delayed in the curriculum until students possess deeper knowledge of their patients and are comfortable in foundational elements of nursing such as examining a patient. Thus, while participants reported many challenges, particularly not having input into nursing curricula, they demonstrated their knowledge and enthusiasm for improving undergraduate nursing curriculum using a re-conceptualist approach.
Bächtold (2013) suggests an important observation about learners, learning and teaching that nurse educators should consider. The author states that the “time scale for learning is not the same as the time scale for teaching” (p. 2483) and that understanding and learning a new model or theory implies that students “construct” new cognitive structures... Therefore the teacher has not only to expose the explicit and communicable models of theories, she\he also has to offer to the students lessons and\or activities that will ensure the required cognitive structures are durable constructed by them” (p. 2483).

The construction of nursing knowledge takes time and cannot be achieved by an artificially imposed timeline such as when students should administer medications. The process of conceptual understanding is not merely cumulative as students need to build connections and links between the new concepts, their acquired knowledge and between concepts. Also, students need to apply the same concepts in various contexts and over a long period in time in order to fully understand and integrate these new concepts (Bächtold, 2013). Furthermore, in examining the transfer of knowledge between the classroom and workplace setting, learning is significantly influenced by the context and setting in which it occurs (Daniels, et. al. 2009) and nurse educators need to re-consider their teaching practice particularly as it relates to medication administration and include the contextual feature that enhance or inhibits safe medication administration in the clinical setting.

**Participants approach to building a teacher and student partnership using a re-conceptualist lens.**

Participants spoke about providing space for dialogue and introducing topics from the students’ clinical experiences in their teaching. Participants provided many examples of guiding students to think about the problems at hand, and encouraged them to bring forward alternative solutions to meet their patients’ needs. I provide two excerpts to further illustrate participants’ progressive, re-conceptual approach to building a teacher-student partnership. Adele, for instance, describes how she encourages dialogue with her students:

> In my group of students, I ask them to be open to any ideas. I would rather know what they think than have somebody who is very scared of their clinical instructor. It’s all about openness, you can teach better when someone is open about their weaknesses and strengths....I have learnt that everybody can learn, everybody can learn. I have learnt that students grow as time passes and they have their own way of learning and applying their knowledge. Everyone has their own technique and its needs to be respected. Respect for the person, as we all want the same, we
Adele seems to encourage and enjoy having conversations with her students about their successes and struggles in their learning about nursing in the clinical arena. Adele shares her insights about how students learn, and states that by giving students space to develop their understanding, she guides them in their development as a nurse. She explains the importance of building respectful caring partnerships with students for learning to occur.

Keisha too explains the importance of building partnerships with students. She states that:

_We are a whole person and not only a nurse. The student is a whole individual not just a nursing student. I love sharing my knowledge, mentoring the younger generation._ (Keisha, 05-05-2014)

Keisha explains that she views the student nurse as a whole person instead of only a student nurse in the encounter. Her understanding of Person includes more than the academic knowledge that the student brings to the interaction and comprises of the student’s values, beliefs, emotions, cultural influences, hopes and dreams, personal attributes such as coping that influences the conversation. Keisha is guided by a broader and deeper understanding of person that guides her in building a partnership with students.

Nested in this excerpt is an ethic of teaching that confirms a progressive approach to pedagogy. In a progressive approach, the teacher treats students as active moral agents with the ability to decide for themselves their personal view of nursing (Hansen1998). The ethics found in a progressive pedagogy stands in sharp contrast to the ethics found in a traditional approach that was addressed in an earlier section of this chapter. Interestingly, Keisha’s approach to students stand in sharp contrast to the traditional approach that she encountered as a student nurse that was also addressed in the previous section.

In a re-conceptualist approach, the central authority of the teacher is lessened as all knowledge, including that of the teacher, becomes the focus of inquiry. Dialogue and debate remain essential elements in this approach and the relationship between teacher and student is more equal as each engages in dialogue with one another.

In the following section, I discuss in more detail the pedagogical context so as to further situate the central theory in the result.
6.4. The Context

In this section, I explain how I am defining the term *context* and then focus on particular results that emerged from the data that relate to context. The context in this study has significance from a methodological and theoretical standpoint. From a methodological viewpoint, the term *context* includes both process and situational context. In examining context, investigators are able to inquire beyond the immediate issue and explore with participants their thoughts and actions about the event as well as examine factors that influence the action of the individual (Corbin & Strauss, 2015). From a theoretical standpoint, context has significance in the data and in this study, context includes the teaching milieu and the relationship between and among the five main concepts that underpin the central theory. An important finding of this study is the lack of consultation or a process for participants to provide input to the curricular development process. This lack of a consultative process further underscores a deeper issue: namely, that the knowledge of classroom nurse educators who develop the curriculum is more valued than the knowledge of clinical nurse educator participants who deliver that curriculum. Clinical educators’ knowledge and decision-making abilities, both important educational resources, are dismissed.

I focus next on the issues of the hidden curriculum and the inequality of power and hegemony between and amongst nurse educators as these contextual considerations emerged strongly in the data from this study.

The hidden curriculum and hegemony can operate simultaneously in a complementary manner to maintain and support traditional pedagogy. Both concepts appear as two sides of the same coin in nursing education and therefore will be addressed concurrently. Also, both terms are rarely found in the nursing education literature, therefore I situate the results within the teacher education literature in order to illustrate this issue.

**Hidden Curriculum in Nursing Education**

Giroux et al. (1981) provide an in-depth explanation of the hidden curriculum, describing it as:

> the contradiction between the official curriculum, namely the explicit cognitive and affective goals of formal instruction, and the “hidden curriculum,” namely the unstated norms, values and beliefs that are transmitted to students through the underlying structures of meaning in both the formal content as well as the social relations of schools and classroom life. (Giroux and Penna as cited in Giroux et al., 1981, p. 211)
In this quote, Giroux explains how teachers and/or school administrators influence students and their learning. The prescribed meaning that teachers give to context, events, and/or situations influences the learners’ thinking, attitude, and actions. Although the influence is often subtle and concealed, it affects students’ learning at a much deeper level and in more profound ways than the official curriculum. Additionally, as the influence is covert it is difficult to uncover and examine.

Giroux et al. (1981) mentions three traditions found in educational theory to explain the structure and meaning of a hidden curriculum and the role of schools in socializing students: a structural-functional view; a phenomenological view; and a radical critical view, also known as a neo-Marxist approach. Each approach provides a set of varied assumptions as it relates to the meaning of knowledge, relationships between teachers and students, and the political and cultural nature of schools. In this discussion, I focus on the neo-Marxist’s viewpoint as it facilitates a more robust examination of structures and processes that operate in supporting the hidden curriculum in undergraduate nursing education. Also, unlike the “apolitical approach of the functionalist approach and the subjective idealism of the phenomenological approach” (Giroux as cited in Giroux et al., 1981, p. 214), a neo-Marxist approach enables educators to examine and link processes found in schools to structures, processes, and influences governing the workplace—an important consideration when examining professional learning.

In this study, participants reported many problems with students’ lack of knowledge and preparation, particularly related to the safe administration of medications. A neo-Marxist approach enabled me to examine how and what students learned and explore factors that influenced their learning. Using this approach I was also able to explore the influences that enhanced and/or inhibited participants in their teaching and I provide two excerpts to uncover the assumptions that underpin the hidden curriculum. In the first excerpt, Margaret shares her concerns about teaching student nurses about administering medications safely to patients in the clinical arena:

*I feel that I need to build my students up by doing a proper assessment. In medication administration I will take that risk and wait until they are ready and able to do it....This will be the first time that they will go through the process of looking up medication, getting the medications, doing the rights, etc. I think it is extremely important that they go through the process each and every step correctly and that they understand the importance of each step....It’s about*
Margaret realizes that students need more time to construct their knowledge on administering medications and knows when the students are capable of administering medications safely to patients; and her knowledge of students’ abilities differs from nurse faculty developing the prescribed curriculum. Margaret realizes that students needed to possess knowledge at a deeper level, such as examining a patient, synthesizing the patient’s data, having in-depth knowledge of medications and their consequences prior to administering those medications to patients. Students’ understanding of a priori nursing concepts would enable students to administer medications safely to patients.

Although patient safety is officially recognized as an important concept in undergraduate nursing curriculum, how it is taught or integrated into the curriculum or how students understand this concept in their practice is not considered. It appears that students’ understanding and/or their ability to fully integrate this concept into their practice is of secondary importance to the focus on efficiency and expediency that underpins a Tylerian approach to nursing education. This disconnect between the official and actual curriculum is problematic as it influences how student nurses perceive the importance of safe patient care in their practice.

Margaret deviates from the prescribed curriculum in her instruction and, instead offers a deeper understanding of the concept of patient safety to the student. Participants seemed to possess a deeper and fuller understanding of this concept than nurse faculty designing the curriculum. The incidental learning of patient safety that occurred in the clinical arena seemed to contribute more to the learning and socialization of student nurses in nursing than the intentional, but decontextualized teaching of patient safety found in the curriculum. The excerpt also reveals the stress and tension that Margaret experienced when instructing students on administering medications to patients and its effect on her teaching.

Although nine participants raised their concerns about the timing of medication administration in the curriculum, their questions and suggestions were all typically ignored and/or dismissed. Nurse educators teaching in the classroom are mainly involved in developing the prescribed curriculum whereas clinical nurse instructors are tasked to implement the curriculum. The hidden curriculum emphasizes the reproduction of certain forms of knowledge and perpetuation of certain behaviors. Freire (1973) states:

Education either functions as an instrument which is used to facilitate the
integration of the younger generation into the logic of the present system and bring about conformity to it, or it becomes the practice of freedom—the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world. (Freire as cited in Giroux et al., 1981, p. 216)

Freire makes an important distinction about the purpose of education and the role of the teacher and, in so doing, contrasts the traditional approach to curriculum and instruction with a more progressive approach. In a traditional approach, only certain forms of knowledge are accepted as Truth and thus these ideas are not open to questioning or deliberation. In a traditional approach there is no space to analyze the “hidden curriculum, in classroom encounters or linking patterns of instruction to corresponding patterns in the larger social order” (Giroux et al., 1981, p. 14). A traditional approach perpetuates conformity and obedience to existing social norms and institutions; whereas, in adopting a progressive approach to education, the teacher encourages students to critically examine their world and provide an alternative explanation and\or solution, thereby assisting students to name, and ultimately change the conditions they find in their practice. I found Freire’s explanation useful in understanding the impact of the prescribed hidden curriculum on participants. Currently, the prescribed nursing curriculum seems to focus on integrating students into existing workplace practices whereas participants tried to discuss the realities that they observed in their students and in clinical practice.

Although Apple (as cited in Giroux et al., 1981) and Pinar (2004, 2012) describe in detail the impact of the hidden curriculum on students in primary and secondary education institutions, I suggest that similar conditions exist in undergraduate nursing curriculum. I found a number of instances in the data where participants spoke about the effect of the hidden curriculum on student nurses’ learning and its impact on their nursing practice. Participants also described the effect on their learning as students and in their teaching experiences. For instance, Adele stated:

To be like one of us you have to be like us. In nursing, we are supposed to provide patient-centred care, [and] advocate for the patient. But we are sending another message—do not do this. The hidden message seems to be more powerful than the obvious message. Advocate for the patient when the hidden message is follow the rules. Follow the rules. And students are smart and they know what is happening. I talk to my students about this as well….If you do not follow the rules, you do not get hired the next semester. (Adele, 12-05-2014)
Advocating for the patients is an important concept taught throughout the undergraduate nursing curriculum. Adele distinguishes how advocacy is conceptualized in the formal curriculum compared to the hidden curriculum. Although students are instructed to advocate for their patients, they are advised to follow the rules found in the prescribed curriculum and in the workplace. These rules suggest that students are not encouraged to ask questions or advocate for their patients or themselves. Instead, student nurses internalize the values found in the hidden curriculum such as conformity and passivity. The ideological assumptions embedded in the informal curriculum perpetuate the dominant ideology found in society, as schools function as agencies of socialization within a network of larger organizations (Apple as cited in Giroux et al., 1981).

Similarly, clinical nurse educator participants were also required to follow the rules and not advocate for themselves or for their students as the consequences for advocating were real. Participants’ behaviors such as speaking up and challenging the authority of the nurse faculty teaching in the classroom could lead to negative and severe consequences, and participants mentioned being placed in a “devil’s triangle” and potentially not being re-hired the subsequent term as a consequence of such a challenge. The hidden curriculum has a negative impact on students and clinical nurse instructors alike. Apple (2004) explains that in order for the hidden curriculum to exist there needs to be a continuous and increasingly sophisticated justification for acceptance of social rules and that this justification sets the “ideological limits of such thinking by embodying appropriate ways in which students begin to reason through the logic of why the institutions and the culture they interact with everyday are indeed legitimate” (p.78). Institutions such as schools and workplaces subscribe to certain norms and behaviors and in doing so perpetuate the normalizing and acceptance of these behaviors thereby legitimizing the particular ways of thinking and behaving forwarded by the dominant culture in society. Apple (2004) encourages educators to become aware of the tacit, unstated norms that underpin the curriculum in order to raise questions and shed light on the problem. Also, he encourages educators to engage in critical reflection and discourse with others in order to mediate the negative effects of the hidden curriculum on their teaching practice.

The impact of the hidden curriculum on learning was also reported by Casey (1996), who assessed the revision of nursing curriculum projects in the United Kingdom. The author found the traditional approach to curriculum development and pedagogy to be pervasive as well as the
presence of hidden curriculum. Casey reported that student nurses were “covertly encouraged to assume passive, compliant and powerless roles” (p. 116), although nurses and nurse educators were taught concepts such as autonomy, holism, and care in their nursing education, thus being provided with contradictory messages in their teaching practice.

The effect of the hidden curriculum on students and nurse educators emerged as an important result and I provide suggestion that nurse educators should consider in the “Conclusion” chapter.

**Hegemony in Nursing Education**

First, I conceptualize hegemony in the education process and then provide exemplars from the data in order to make visible aspects of hegemony observed in the description of teaching practices of nurse educators. I focus on a particular education scholar’s explanation of hegemony as I found it useful in examining and situating the unequal power relations between the two groups of nurse educators that emerged from the data. The two groups of educators that emerged from the data are the nurse faculty teaching in the classroom and chiefly involved in developing the prescribed curriculum, and clinical nurse instructors who are tasked to implement the curriculum. I integrate particular aspects of critical pedagogy introduced earlier in the “Literature” chapter of this thesis and focus particularly on the explanations provided by education scholar Apple (cited in Giroux et al., 1981).

In examining the notion of hegemony, I concur with Apple (cited in Giroux et al., 1981) that hegemony is not merely the overt control and manipulation of individuals by a few people with power. Instead, as Apple suggests, hegemony acts to saturate our very consciousness so that the educational, economic and social world we see and interact with and the commonsense interpretation we put on it become the world, tout court, the only world…refers to an organized assemblage of meanings and practices, the central effective and dominant system of meanings, values and actions which are lived. (Apple as cited in Giroux et al., 1981, p. 113)

Apple advances a robust and substantive understanding of hegemony and explains hegemony as being able to influence individuals’ understanding and interpretation of events and/or situations without their realization. Hegemony is sophisticated, yet subtle, as it enables individuals to adopt the ascribed meaning and alter their personal perception and understanding of events, thereby maintaining and perpetuating the influences of the dominant culture.
Hegemony also affects the discourse and relationships amongst individuals and this influence is pervasive and deep-seated, making it difficult to name, examine, and change.

First, I provide an excerpt that reveals the more obvious, overt form of control then provide another excerpt to illustrate the more sophisticated, covert method of control described by Apple (cited in Giroux et al., 1981). Paris stated:

*As a part-time teacher you can’t rock the boat, openly or verbally. Even the strategies put you at risk. You are in a devil’s triangle. If you let your students do it, there is potential issue with College of Nurses [sic-professional regulatory body]. If you tell the student don’t do it, and it gets back to the lead, you need to justify it to her....It is very difficult to stand up to this as a clinical teacher. We are in a very precarious position where they don’t have to bring you back next term.* (Paris, 09-07-2014)

The above excerpt reveals the tension and stress that Paris encounters while having to consider and decide among conflicting obligations; teaching in a manner that she considers appropriate for students, her professional obligations as a nurse educator, the suggestions of the course lead, and the unstated consequence which could have a negative impact on her employment status. As Paris considers and weighs each oppositional factor in her decision, she considers her ethical responsibilities to students against the financial consequences to her employment. Most participants alluded to but did not explicitly state this potential consequence but many clearly articulated that if they raised questions or concerns it could have a negative impact on their teaching practice. The consequences of “rocking the boat” and speaking up supports and perpetuates the existing culture and power dynamic found in nursing education departments.

Similarly, Adele spoke about her personal experience of not having input into curricula or program decisions. She mentioned:

*Students feel they don’t have a voice. As a clinical instructor I do not have a voice. I don’t. I don’t. Even when I question some of the practices that I see on the course outline, it does not affect anything.* (Adele, 12-05-2014)

Even though Adele raised questions and concerns about the curriculum, her concerns were dismissed. Many participants also shared their concerns about the lack of valuing of their knowledge while others mentioned many instances where their voices were silenced or ignored. The dismissal and minimizing of participants’ concerns are examples of hegemonic practices
found in schools of nursing. The covert message from the nurse educators teaching full-time in the departments of nursing education seems to significantly affect the lives and deliberations of clinical nurse educators.

Participants reported that the lack of input into the course curriculum was problematic. Sally mentioned:

*The fact that I was not allowed to teach the way I knew was safe, even if the people above me who had designed the course had never seen such a thing. So they were not open to changing based on something that I had discovered in practice. I was not valued for my experience. Students suffer because of that. I have to re-teach in the practice placement about something as simple as how we could give a needle.* (Sally, 16-05-2014)

Sally speaks about teaching students how to safely recap a needle and how her knowledge and clinical expertise is ignored. She raises concerns about the type of knowledge that is deemed worthy in nursing and that the authority of those who possess these particular forms of knowledge seems to be valued over the knowledge that participants bring to their teaching practice.

Apple (cited in Giroux et al., 1981) examines knowledge claims in maintaining and supporting the dominant culture and states that “this selection of knowledge that is made available or not available to students reinforces the school as an institution in perpetuating and the recreation of .. power and inequality” (Apple as cited in Giroux et al., 1981, p. 115). Apple notes that practices such as the selection of certain content and de-selection of other content, where certain ideas and meanings are forwarded and rewarded while other perspectives are discarded and ignored, exacerbate hegemonic practices. The results of such practices influence individuals’ experiences and the meaning of these experiences, and as such deeply influence their construction of knowledge, and the resulting understanding of the context becomes an important factor influencing the students’ identity, outlook, and being in the world.

Participants reported that their suggestions and recommendations for changes with the curriculum were ignored and dismissed and only certain types of questions were publicly considered, thereby supporting and perpetuating a culture of silence. Savannah explains the changes in her perceptions of being a nurse educator and identifies the impact of hegemony on her teaching practice. Savannah mentions her personal values and beliefs about teaching and is ambivalent about her purpose as a nurse educator:
I thought it was different and it was about promoting learning. All teachers would be good role models. But my vision has changed. I thought it’s about who you are, and what you put into it, you will get out of it. If you apply yourself, you will succeed. But it’s not true. What I believed is not true, what I believed was not true, that we promote learning, that we are facilitators of learning. I consider myself a facilitator of learning. I am here to get you to where you want to go. It so confusing because it’s not true anymore. (Savannah, 15-030-2014)

Savannah reflects upon her observations and teaching experiences in this excerpt and finds that certain assumptions that had initially influenced her teaching, such as guiding and facilitating student nurses in their journey to becoming a nurse, are not mirrored in her experiences with other nurse educators in her nursing education department. Although Savannah has been teaching for over seven years in the clinical arena and completed formal studies in education, the contradictory messages from nurse colleagues causes her to doubt her purpose and her role as a nurse educator. In essence, hegemonic practices have normalized the values and attitudes of the dominant culture, creating a culture that isolates voices that challenge those dominant cultural assumptions. I found that participants with formal knowledge of education and participants with more than nine years of teaching experience were able to identify hegemonic practices more readily than participants with fewer years of teaching experience. This finding has important significance for nurse administrators in nursing education and is discussed further in the final chapter “Implications and Recommendations”.

Apple (cited in Giroux et al., 1981) builds upon and extends the work of other education scholars such as Gramsci in explaining how hegemony operates in schools and education institutions as agencies of a dominant culture. The author acknowledges schools as a place of social training in

the process of education; the process of a much wider social training within institutions…the selective tradition at an intellectual and theoretical level-all these forces are involved in a continual making and remaking of an effective dominant culture, and on them as experienced, as built into our living, reality depends. (Apple as cited in Giroux et al., 1981, p. 114)

Apple describes how the institutional re-creation of certain ways of thinking and knowledge occurs within the context of schools that influences the individual’s perceptions of real life experiences. Although Apple focuses on elementary and high schools in his analyses, I suggest a similar thinking and logic operates as structural constraints in undergraduate nursing
programs. For example, participants wanted to connect the timing of particular aspects of curriculum until students possess more knowledge and experience in the clinical area. However, their concerns and input were ignored, and in part because there are no clear institutional locations for this kind of discussion to take place. It seems that certain topics, courses, and knowledge forms are privileged and the knowledge and judgments of nurse educators instructing those particular courses has a higher value in nursing departments thereby reducing or eliminating ways to create change. The net result of such processes is a learning context that perpetuates conformity and obedience to authority as the preferred stance. This contradiction in messaging confounds people’s personal experiences and ensures the perpetuation of the existing status quo in nursing curriculum. Furthermore, even though most clinical nurse educators have formal knowledge of nursing and are familiar with current practice environments they remain invisible throughout the curricula decision-making process in undergraduate nursing programs.

In examining the concept of culture that supports hegemony, Giroux provides a rich and multifaceted viewpoint. Instead of merely adopting an anthropological or sociological understanding of the concept, Giroux explains,

Culture in this sense, would be defined not simply as lived experiences functioning within the context of historically located structures and social groupings but as “lived antagonist relations” situated within a complex of sociopolitical institutions and social forms that limit as well as enable human action. (Giroux as cited in Giroux et al., 1981, p. 420)

Nested in this understanding, Giroux explains that culture is more than the mere expression of individuals’ experiences within socio-political-economic conditions found in society and provides a unique way to understanding culture found within schools and education institutions. He explains that culture consists of oppositional experiences of individuals mediated by power and struggle and rooted in the structural oppositions of labour and capital. Culture is established as a political concept where power is used unequally to produce different meanings and practices that reproduce a particular kind of society that satisfies the interest of the dominant culture. When we examine the culture found in education units in nursing through this lens, we see how education is a political process and that teachers need to recognize their role in maintaining the perpetuation of the dominant culture. I found Giroux’s conceptualization of culture particularly useful as it enabled me to examine the underlying power dynamic between participants and the classroom nurse faculty found in the data. Participants repeatedly reported
their ongoing struggles with classroom nurse faculty in making changes to the curriculum and the consequences of challenging their authority. The concern of clinical nurse instructors as it relates to student learning about patient safety were dismissed and ignored. The prescribed curriculum focused on meeting the needs of the dominant culture through completing specific tasks on time, including administering of medications. The learning needs of students, the variability in their understanding of patient safety, and the instructional needs of clinical nurse instructor participants’ seemed to be relegated to a less important and subordinate position.

Giroux (1981) acknowledges that although power has the ability to constrain individual choice, individuals still have the ability to shape and transform their lives and echoes similar sentiments raised by Freire (1998) and Dewey (1938/1997) in acknowledging the emancipatory potential of education. Participants seemed to adopt a more progressive approach to instruction and in so doing could contribute to lessening the impact of hegemony in the education of student nurses.

Apple (cited in Giroux et al., 1981) also provides some important recommendations that could apply to nurse educators in considering their practices. Apple suggests that teachers should engage in critical reflection and dialogue with others in order to uncover the influences of dominant ways of thinking in their teaching practice. The author states that in its very production and dissemination as a public and economic commodity…the ideological, social and economic values are embedded in the institution we work in, in our modes of teaching and in our principles, standards and forms of evaluation. Since these values now work through us often unconsciously, the issue is not how to stand above the choice. Rather, it is what values we must ultimately choose. (Apple as cited in Giroux et al., 1981, p. 117)

This notion of unconscious and ideological positioning occurs at a much deeper level and is therefore not easily understood or examined. Apple suggests that teachers engage in reflection, dialogue, and debate in order to uncover the influences and biases that influence their teaching. Participants in this study provided a number of examples of reflecting on their teaching practice on a regular basis, and reported that such reflection informed and advanced their teaching.

Participants’ approach to curricula development and pedagogy is supported by other nurse educators (Benner, 2010; Diekelmann, 2004). Similarly, McAllistor (2005b) suggests that nurse educators move away from transmitting information, beliefs, values, and solutions to students and instead build on students’ own capacity to create change. The author suggests that nursing
faculty adopt a dialectical critique of practice as “it exposes the complexity and ambiguity and shifts the discussion of practice to examination of praxis” (p. 15). In this thesis, praxis is explicated as thought, reflection, and action.

**Summary of Chapter**

In summary, I explicated the central concept that underpins this study: *The Pedagogical Practices of Clinical Nurse Educators and Navigating Constraints in Complex Educational Institutions*, and discussed the important concepts that contributed to the emergence of this concept. I provided excerpts to illustrate important concepts and situated each in the literature. Also, I contrasted two approaches to teaching and, in doing so, expanded on particular ideas found in the “Introduction” and the “Literature” chapter. In the next chapter, I discuss the implications of particular results for nurse educators to consider.
Chapter 7.0 Conclusions, Implications and Recommendations

Overview of chapter

In this chapter, I examine the implications of findings that emerged from the results on the varied stakeholders in nursing education. I then provide two important recommendations for nurse educators to consider. At the end of this chapter, I discuss particular areas for future research.

In the Results chapter, I described the emergence of basic and sub concepts using grounded theory methodology suggested by Corbin and Strauss (2008, 2015) and Charmaz (2010) and described how each sub concept contributed to the emergence of the main concepts. These five main concepts were; the Forms of Knowledge that clinical nurse educator participants brought to their teaching practice; Ethics in teaching, Approaches to teaching and the Context were further conceptualised and addressed in the discussion chapter. In the discussion chapter I explained the central theoretical ideas that emerged from the data. The central concept, The Pedagogical Practices of Clinical Nurse Educators and the Navigation of Constraints in Complex Educational Institutions emerged as a substantive theory in this study. The results from the data highlight significant problems related to curricular development in undergraduate nursing education, problems associated with using a traditional approach in developing and implementing curricula; the lack of formal preparation in instruction for nurse educators and its effect on teaching and learning and problems related to the teaching milieu. These results have implications for all nurse educators, nurse administrators, the accrediting body for nursing education and policy makers and I discuss the implications for each stakeholder group in the following section.

7.0. Implications of Study Results

7.0.1. Nurse Educators

I focus in this section on four important results that emerged from the data and their implications for nurse educators and nurse administrators in undergraduate nursing programs. These results are the importance of formal knowledge of instruction for nurse educators, the importance of mentoring opportunities for clinical instructors, the need for clinical instructors’ input into curricular decisions and problems related to incivility found in nursing education units.
**Formal knowledge of instruction**: The results reveal that the four clinical nurse educator participants with formal knowledge of instruction were able to plan their teaching interventions more effectively than participants with nursing knowledge and only teaching experience without formal instructional training. Also, these four participants shared important insights about the current curriculum and made considered suggestions that could improve learning in the clinical arena. This is a significant finding as it reveals the importance of formal preparation in education in informing and improving the teaching practices of nurse educators. In the next section, I provide a broad overview of what such an education program for nurse educators might include.

**Mentoring and Sharing Opportunities**: All participants mentioned the lack of sharing and mentoring opportunities as factors that contributed to their stress in teaching in the clinical arena. Additionally, I found that the data suggested a lack of opportunity to share teaching experiences negatively impacted participants’ ability to develop their knowledge of instruction and to improve the quality of their teaching. Participants also reported that they encountered many ethical issues in their teaching practice and had to seek assistance on an individual basis in order to learn how to resolve these issues. I suggest nurse educators could participate in a collaborative learning structure used by teacher educators and adopt a communities of practice approach (Drummond-Young et al, 2010; Servage, 2008; Wenger, 2000) where teachers’ professional learning work involves collaboratively sharing information, problem solving, and developing pedagogical knowledge and skills. Furthermore, all nurse educators, classroom and clinical nurse educators should be able to participate in these communities of practice where they would be able to share ideas, brainstorm, plan teaching sessions, develop curricula, and critically evaluate their teaching practice. A professional learning community consisting of new and seasoned nurse educators, clinical nurse instructors and classroom nurse educators could provide socio-emotional support to all its members creating a supportive learning context that would also enable nurse educators to share good teaching practices. Also, nurse educators would be able to address the negative behaviours displayed by its members in a comprehensive manner.

**Clinical Instructor voice in curricular decision making**: Participants frequently mentioned their lack of voice in curricular decisions and feeling undervalued as a member of the teaching team. The data also revealed that although clinical nurse instructors were solely responsible for implementing the curricula they were invisible in the process of developing those curricula and in the ongoing decision making process related to instruction. Nurse educators
teaching in the classroom and nurse administrators in education institutions need to ensure that all stakeholders, including clinical instructors and students, be encouraged to participate in curricular committees; and that all nursing faculty have voice in the decision-making process in the curriculum. The findings from this study also made visible that nurse educators, many with doctoral preparation in nursing rather than nursing education, were mainly involved in developing curricula. Participants shared many exemplars such as that of medication administration that vividly illustrate the negative impact of incoherent and fragmented curricula on the teaching practices of clinical nurse instructors, student learning and the care that student nurses provide to patients. Nursing faculty on curriculum committees should instead have formal knowledge of curricula development, pedagogy, current knowledge of nursing practice and education literature so that they develop coherent, relevant and informed undergraduate nursing curricula.

**Incivility in nursing education programs:** The culture of teaching in nursing and its negative impact on participants emerged as another significant finding of this study. It seems clear that all nurse educators, including nurse educators in formal leadership positions in academic units, contribute to creating a culture in the education unit. Critical theorists like Giroux et al., (1981) suggest that educators need to learn to examine in critical ways the factors that influence culture, power and oppression in their teaching practice. I suggest that the nurse educators consider reviewing the teacher education literature to further explore the value of using a critical pedagogical approach to examine current practices in the development, design and implementation of nursing curricula. In general, I strongly recommend that nurse educators collaborate with teacher educators in order to learn more progressive ways of teaching and building effective partnerships with colleagues, students and others. Also, teacher educators’ knowledge and understanding of the assumptions and biases that influence educators in their development of a curriculum is another resource that nurse educators could consider.

The findings from this study support the findings from previous studies reporting significant levels of incivility amongst nursing faculty (Clark, 2013; Clark & Springer, 2010; Peters, 2014). Clark (2013) conducted a quantitative survey of five hundred and eighty-eight nursing faculty in the United States. She found that 71% of respondents held academic positions as assistant, associate, or full professors; 62% taught mostly in associate or baccalaureate programs; while 55% taught in graduate programs in nursing. Respondents reported negative
behaviours such as being insulted, berated, undermined, and sabotaged, which left them feeling “angry, demoralized and frustrated that incivility was often tolerated, ignored and allowed to occur” (Clark, 2013, p. 101). Nurse administrators need to have formal preparation in best practices of academic leadership in order to promote a culture of civility, which, in turn, would improve the work satisfaction of clinical nurse educators.

### 7.0.2. Implications for Nurse Administrators in Nursing Education

Participants mentioned particular organizational problems found in nursing education units that constrained their teaching practice. These concerns relate specifically to a wide range of problems, including instructor-student ratio, twelve-hour length of the clinical shift, lack of orientation and mentoring opportunities for clinical educators and hiring practices found in nursing education units and I address each problem separately in the section below. By addressing these problems nurse administrators could improve the work satisfaction of clinical nurse educators and improve the recruitment and retention of seasoned clinical nurse instructors.

**Instructor-student ratio**: The current instructor-student ratio of 1:8 needs to be examined critically as it does not enable clinical nurse educators to instruct students effectively. The teacher-student ratio is an arbitrary ratio and requires urgent research-informed scrutiny. This ratio has remained static over many years although the learning needs of student nurses has changed, the acuity of patients have increased over the years and the health care context has changed considerable over the years. Aside from the workload problems, the current teacher-student ratio does not enable nurse educators to develop their knowledge of teaching, an important area in the scholarship of teaching in the discipline.

**Twelve hour length of clinical shift**: Participants also mentioned the negative impact of a twelve-hour shift on student learning. This is an important area for future study as the length of a clinical shift that appropriately influences student learning is yet to be researched.

**Orientation and Mentoring**: The results from this study reveal that although clinical nurse instructors were tasked with implementing the curricula that they received minimal education and/or support from nurse faculty. Participants stated the need for structured orientation and timely education sessions throughout the academic year. Nurse administrators need to provide both, education and financial support for clinical instructors to attend the orientation programs offered by the academic institution and the nursing department. I suggest that clinical nurse instructors attend both orientation programs so as to learn about each in order
to enhance their knowledge of each and inform their teaching practice. Also, generic institutional induction structures should be tailored to meet the specific needs of educators (Boyd & Lawley, 2009; MacIntyre, Murray, Teel, & Karshmer, 2009; Macneil, 1997; Murray, 2005). Similar to the role played by teacher educators in teacher education programs, nurse educators need knowledgeable, experienced and enthusiastic mentors as they transition from the role of nurse to that of nurse educator. Both, formal and informal mentoring opportunities are important in the development of a nurse educator and should be facilitated by leaders in departments of nursing (Boyd, 2010; Boyd & Lawley, 2009; Boyd & Harris, 2010; Kenny, Pontin & Moore, 2004; McKeon & Harrison, 2010; Wenger, 2000).

**Hiring practices in nursing education units:** The findings from this study revealed that nurse educators with formal preparation in education contributed positively to curricular development and pedagogy in nursing. These participants were better able to tailor their instruction, construct their pedagogical content knowledge and in doing so guide student nurses in their learning. Currently, most nurse administrators hire nurse educators with graduate degrees in nursing as this is the preferred credential in nursing education (Princeton, 1992). I recommend that nurse administrators reconsider their hiring practices and hire nurses with graduate preparation in nursing and education.

The results from this study also indicate that nurse administrators should consider hiring graduates with at least seven to eight years of nursing experience as new nurse graduates need to build on their current and experiential nursing knowledge in order to develop a deeper understanding of nursing and their pedagogical reasoning skills so as to become effective facilitators of learning in the clinical arena.

Participants reported stress related to their working conditions and this result is consistent with a study by nurse researcher Ferron (2013). Ferron (2013) conducted a cross-sectional survey study of part-time nurse faculty in Ontario, Canada. The purpose of the study was to examine the factors that had a positive or negative effect on nurse faculty’s intent on remaining employed in the academic institutions. Ferron invited two hundred and eighty-two part-time nurse educators employed in colleges and universities in Ontario to participate in the study; one hundred and nineteen participants responded (47.9% response rate). Ferron reported that factors such as support, formal and informal recognition, and fairer work procedures enhanced the retention of nurse faculty in academic institutions. Although the author studied part-time nurse educators, I
contend that these same factors could also improve the working conditions of clinical nurse instructors. I suggest that nurse administrators, by improving the working conditions of clinical nurse educators, particularly as they relate to instructor-student ratio and clinical placement issues, could improve the recruitment and retention of seasoned clinical nurse instructors.

7.0.3. Implications for the Accrediting Body and Policy Makers

In this sub-section, I first discuss the implications of the results for nurse accreditors and then for policy makers.

**Nurse Accreditors:** The following two results are important considerations for nurse accreditors to consider when assessing each nursing program. These results relate to the theoretical approaches that nurse educators bring to developing curricula, the conceptualisation and positioning of patient safety in developing and implementing undergraduate nursing curricula. Findings from this study highlight the important differences between the traditional and the re-conceptual approach and the impact of each approach on curricular development and pedagogy on student learning. The traditional, behavioural approach was found to have a generally negative effect on instruction and student learning whereas the constructivist approach had more beneficial effects on student learning, instruction and on building partnerships. Nurse educators need to make explicit their underlying theoretical approaches to curricular development and instruction and ensure that if a re-conceptualist approach is used, that it be well-integrated and made visible throughout the education program. Also, detailed considerations of patient safety should permeate the development, design and implementation of all nursing curricula and how that content is taught. Nurse educators need to possess a deeper, more progressive understanding of patient safety to inform their curricular and instructional decisions. Important aspects of curricular decision making such as informed decision-making, effective communication, team work, and a supportive learning environment, are all important elements that underpin safe patient care (Chenot & Daniel, 2010; Debourgh & Prion, 2012; Onge, & Parnell, 2015; Tella et al., 2014) and should be visible in the development and design of undergraduate nurse education program.

**Policy makers:** The findings also revealed that clinical nurse educators with formal preparation in education were more effective in their teaching practice than nurse educators with preparation in nursing alone and this result has implications for policy makers and funding agencies in nursing education. Effective teaching in this study is conceptualised as guiding and
enabling students in their intellectual and moral development as individuals (Hansen, 1998; Strom, 1989).

I suggest that policy maker’s reconsider the policies of the 1960s (Prior, 1965) discussed in the Introductory chapter and its effect on the preparation of nurse educators as it relates to the education preparation of future nurses. I suggest that in practice disciplines such as nursing, nurse educators require formal knowledge of curricular development in addition to knowledge of nursing and ability to conduct research.

In 2009-2010, CASN, the accrediting body for schools of nursing in Canada, conducted an environmental scan on doctoral programs in nursing in Canada. The purpose of the scan was to examine the factors that contributed to the increase/decrease of student enrollment in doctoral programs in nursing. The result revealed approximately fifteen schools of nursing offering doctoral programs in nursing. Six (46%) of the fifteen nursing programs reported that potential doctoral candidates had requested a program other than those offered by the school of nursing, while two (15%) reported a lack of funding (CASN 2010). Furthermore, in 2014, CASN reported statistical information on the education preparation of nurse educators in Canada. The results revealed a decrease in student enrollment in doctoral programs of 4.5 % (66 students) from the previous year. This is an important result as doctoral education is the preferred credential in hiring in nursing education (Princeton, 1992). It seems that more program options in doctoral studies and improved funding would increase nurse enrollment in doctoral programs and address the acute shortage of nursing faculty. Also, nurse educators enrolled in doctoral programs in education should be acknowledged for their contribution to the discipline.

7.1. Recommendations

I propose two recommendations that emerged from my study results, one relating to the education preparation of nurse educators and the other, to adopt a re-conceptual approach to developing undergraduate nursing curricula.

7.1.0. An Education Program for Nurse Educators

Participants with formal preparation in teaching seemed to be able to assess and plan their teaching interventions more effectively than participants with nursing knowledge alone and this emerged as a significant finding in this study. I recommend an education program for all nurse educators so that nursing faculty learn to teach using progressive approaches found in education, have an opportunity to practice progressive ways of instruction, and in doing so improve their
knowledge in developing nursing curricula and instruction. I suggest that such an education program be developed collaboratively between nursing faculty and teacher educators so that nurse educators’ learn progressive ways of teaching from teacher educators. Moreover, in order to change the existing culture found in education units in nursing, nurse educators’ need to learn new ways of building partnerships with others and relating more effectively with students. I suggest that the experiences of teacher educators’, and research on best practices in pedagogy found in teacher education literature would benefit nurse educators in their teaching practice and improve the scholarship of teaching in nursing.

The findings from this study indicate that participants with formal preparation in education and participants with more than ten years of actual nursing practice seemed to be more effective in guiding student nurses with their learning. I suggest that a doctoral program in nursing education would provide an appropriate education option that nurse graduates could consider. Also, an education program for nurse educators would mitigate the problems associated with shortage of qualified nurse faculty discussed in the introductory chapter. I provide a broad overview of an education program for nurse educators and draw specifically on the works of education scholars such as Cochran-Smith (2003); Cochran-Smith and Lytle (1999); and Fenstermacher (1994).

I concur with nurse educators Diekelmann and Gunn (2004) who first recognized the uniqueness of the nurse educator role and suggested the importance of an education program for nurse educators. Similarly, nurse researcher McAllistor (2005b) in studying the teaching practices of nurse educators, found that “training models wherein a knowing expert shows a novice a way of performing and insists on replication without adaptation or deviation is a form of indoctrination...nursing has long felt the damaging effects of such a model” (p. 14). McAllistor explains that nurse educators need to learn to teach using progressive teaching ideas and methods and that they need to be educated in progressive pedagogies so that they educate and not merely train student nurses. Other nurse scholars (Benner et al, 2010; Diekelmann, 1997, 2004; Diekelmann & Scheckel, 2004; Ironside, 2001, 2005b, 2014; Nehls, 1995; Tanner, 2007a) have also suggested that nurse educators need formal preparation in order to teach. Additionally, other educators (Casey, 1995; Stanley and Dougherty, 2010) also concluded that clinical nurse instructors need to develop teaching skills in order to enable each student to reach her\'s potential. Education scholar Shulman (2005) concluded that educators need to move away from
an ‘apprenticeship of observation’ (p. 57) and suggested that instead, all faculty members receive direct preparation to teach. This would help address the problem where instructors tend to simply model their own teaching on the teaching approach to which they themselves were exposed, and not on a more current and research-based approach.

Fenstermacher (as cited in Shulman, 1987) stated that the goals of teacher education should enable educators to reason soundly about their teaching as well as perform skilfully using thoughtful teaching interventions. Sound reasoning requires a process of thinking about knowledge of facts and principles from which to reason and from which to develop actual teaching practice. Similarly, Cochran-Smith (2003) added that a curriculum for teacher educators is an ongoing, recursive process where the relationship between the knower, that is, the teacher educator and knowledge, is generative and tentative because, based on constructivist views of learning, professional knowledge of pedagogy is self-constructed. A curriculum for nurse educators should include “discipline knowledge and clinical expertise” (Shulman, 2005. p. 53) as well as issues and concerns of teacher educators, provide teacher educators with opportunities to reflect and analyze their teaching practices and reflect on their commitment to broader social goals (Murray, 2005). In order for a teacher to engage in the creation and use of knowledge simultaneously, the teacher should have a good grasp of formal learning theories and engage in critically evaluating their own practice (Fenstermacher, 1994). I add that graduate students in doctoral programs in nurse education programs should have a thorough understanding of nursing, possess experiential nursing knowledge and have a good grasp of current nursing practice.

Shulman (1987) provided a framework that educators consider in developing such an education program and stated that the program should include the foundational sources of knowledge as well as experiences that constitute their personal knowledge of teaching that teachers could draw upon. The curriculum should also include “philosophical and historical matters related to education” (Shulman, 1987. p. 8), knowledge related to developing curricula, rich instructional repertoire of teaching strategies, and professional understanding of the educational context. Also, the curriculum should also include knowledge of students and their learning needs.

Education scholars (Cochran-Smith, 2003; Cochran-Smith & Lytle, 1999; Clandinin & Connelly, 1987; Kosnik et al., 2011) have written extensively on the education preparation of
teacher educators and the knowledge that experienced teachers bring to their practice. These authors suggest that an education program should focus on the individual teacher’s learning needs, her/his prior knowledge and experiences as well as consider certain aspects such as group dynamics, effective communication, developmental, personal growth, and organizational competencies (Kosnik, et al, 2011; MacNeil, 1997; Murray & Male, 2005). I contend that teacher education research and experiences of teacher educators would guide nurse educators in developing and improving their teaching practice and in developing the scholarship of teaching in nursing, an important focus in the evolution of the discipline.

I contrasted the education requirements of teacher educators from teacher education literature with the competencies requirements for nurse educators found in nurse education literature and found some important differences. I found that competencies for nurse educators focused primarily on the behavioral, performative aspects of teaching whereas teacher educators focused more on the teachers’ thinking, their “mental lives” (Freeman, 2002. p. 2) and the teaching experiences that informed their practice. For instance, the Australian Nurse Teachers’ society (ANTS), a professional nursing organization in Australia developed particular competencies for nurse educators (Guy, Taylor, Roden, Blundell & Tolhurst, 2011; Kalb, 2008). Similarly, the National League of Nurses (2005), the professional body of nurse educators in the United States compiled a list of core competencies that nurse educators should possess. I found that these competencies in both nursing organizations used the transmission model of teaching, “the process-product paradigm” (Freeman, 2002. p.4) that links the teacher’s action and instructional strategies with student learning. The assumptions that underpin a transmission model of teaching and its impact on student learning have been thoroughly discussed in earlier chapters and will therefore not be addressed here, but I want to emphasize again how much the transmission model remains the major paradigm for teaching in nursing. In contrast, the literature on teacher educators focuses on the knowledge that a teacher brings to her/his work, the assumptions and beliefs that guides her/his practice, pedagogical reasoning, and experiential knowledge in addition to their instructional activities. Teacher education literature builds on the assumptions found in constructivism and constructivist pedagogy, and teacher education research, particularly in the late 1980s (Freeman, 2002), sheds considerable light on the knowledge of teaching that teachers bring to their practice. It highlights that instruction is more than merely knowledge of content, particular teaching methods or relaying information; rather, it
includes teacher’s thinking and concepts such as pedagogical content knowledge and pedagogical reasoning, areas discussed in detail in earlier chapters. I suggest that an education program for nurse educators review relevant research done by teacher educator scholars so as to improve the teaching practice of nurse educators.

Nurse educators including clinical nurse instructors should also engage in ongoing professional development activities. Cochran-Smith and Lytle (1999), note that “teachers learn when they have opportunities to examine and reflect on the knowledge that is implicit in good teaching…to improve teaching, then teachers need opportunities to enhance, make explicit and articulate the tacit knowledge embedded in practice “(p. 62). These authors suggest that by sharing teaching experiences, teacher inform and learn from each other. Similarly, nurse educator Drummond-Young et al., (2010) suggested a faculty development model for nurse educators to consider. The model builds on social constructivist ideas, such as communities of practice (Wenger, 2000) and consists of four components; instructional development, professional development, leadership and guiding nurse educators in engaging in activities that influence organizational polices. Nurse educators’ and nurse administrators could work collaboratively in modifying or adapting the model to meet their particular professional needs.

Furthermore, the role of the clinical nurse instructor should be re-conceptualized in order to support clinical educators in discussing their concerns related to safe patient care. Participants in this study reported “not wanting to rock the boat” and “finding themselves in a devil’s triangle” and that the culture found in the education units did not support participants to voice their concerns. Similarly, MacIntyre, et al.; (2009) noted that when faculty and students found poor nursing practices in the clinical facility that were inconsistent with current research guidelines, they often discussed these practices in private because they considered themselves to be visitors who “should not challenge the status quo”(p. 449). I concur with the MacIntyre et al., (2009) suggestion that clinical nurse instructors share their observations and guidance with staff nurses and unit nurse managers in ways that promote collegial relationships, safe patient care and emphasize the importance of professional integrity to students. However, the results from the current study indicate that clinical nurse instructors need support and guidance from their course leaders and nurse administrators in order to feel confident enough to raise these types of issues with the facility. A collaborative and supportive atmosphere would enable clinical nurse instructors to bring forward their concerns as well as propose suitable alternatives.
Rodgers and Jenkins (2010) examined the traditional supervision model with student teachers and discuss three alternative supervision models for educators to consider. These models are a paired teaching model, a partnership model and a paired dyad model and although there is some overlap between and amongst the models, each model offers particular benefits. I suggest that nurse educators consider each model, examine the benefits and drawbacks of each model and adopt a model that best addresses their particular needs.

7.1.1. A Re-Conceptualist Approach to Developing Undergraduate Nursing Curricula.

My second recommendation relates specifically to the need for a more comprehensive theoretical approach to developing undergraduate nursing curricula. Also, I address the importance of an integrated and progressive approach to embedding concepts related to safe patient care in the development, design and implementation of undergraduate nursing curricula. This recommendation is a significant contribution to nursing education as a re-conceptualist approach includes shifting the theoretical assumptions underpinning curricular development, pedagogy, and teacher and student partnerships, considerations that are largely missing in current nursing education literature. In this sub-section, I first review the purpose of nursing education; I then briefly describe some of the main problems found in nursing curricula described in the literature before presenting a re-conceptualist approach to developing undergraduate nursing curricula that nurse educators should consider.

I concur with nurse scholars Benner, (1993) and Walker, (2005, 2009), that nursing is a practice profession and that student nurses need to include many forms of knowledge including theoretical, practical, embodied, experiential, ethical and spiritual in their nursing practice. Education scholar Shulman (2005) adds, “Professional education is not education for understanding alone; it is preparing for accomplished and responsible practice in the service of others...They must come to understand in order to act and they must act in order to serve (p. 53). Student nurses need to understand the information at a deeper level in order to develop their knowledge of nursing and the care that they provide to patients. Nurse educators need to guide students to integrate the many forms of knowledge found in nursing in their practice, as well as guide students to challenge issues that they encounter and provide solutions for change.

Study results indicate that student nurses were given large amounts of information and were inadequately prepared to critically analyze that information and then use it to make sound decisions in order to practice in a competent and safe manner. These issues were very evident in,
for example, the excerpts on medication administration. Similar results have been found in other studies. For example, nurse researchers Jantzen (2012) and Wilber (2014) studied nurses in their practice arenas. Although both researchers studied slightly varied groups, both came to the same conclusion that nurses need to possess good reasoning and clinical judgement skills in order to practice effectively and safely in providing patient care. Nurse educators and education scholars (Casey, 1995; Doane & Varcoe 2008; Doane & Brown 2011; Duncan & Schulz 2015; Giddens & Morton, 2010; Stanley & Dougherty, 2010), add that nursing curriculum should be revamped in ways that enable teachers to equip students with skills to think critically and analyze information carefully, and where students are nurtured to reach their potential.

Results from Benner et al, study (2010) indicate that the “practice-education gap already untenable will continually widen unless nursing education overhauls its approach to nursing science…to be safe and effective practitioners nurses need to enter practice ready to draw on knowledge ”(pg. 4). These authors add that nursing education needs a radical transformation and recommend that nurse educators re-examine their teaching practice and adopt “approaches to teaching and student learning that will best prepare both today’s and tomorrow’s nurses. Indeed, we call for radical changes in nursing education, a radical new understanding of the nature of curriculum and pedagogy” (p. 8). I concur with Benner et. al’s recommendation that a radical transformation of nursing education is required and suggest that nurse educators consider a re-conceptual approach to developing undergraduate nursing curricula. This comprehensive approach provides a rich, substantial, evidence informed and multi-layered guide to developing nursing curricula and pedagogy.

A Re-Conceptualist Approach to Curriculum Development

Based on the results from my study, I propose that nurse educators integrate broad ideas found in constructivism and adopt a re-conceptualist approach in developing undergraduate nursing curricula. The purpose of education conceptualised by Tyler and described in the Literature and Discussion chapter is at odds with a re-conceptualist approach. Pinar (2004) suggests that education is not merely the acquisition and exchange of information and states that:

being informed is not equivalent to erudition. Information must be tempered with intellectual judgment, critical thinking, ethics and self-reflexivity. This complicated conversation that is curriculum requires interdisciplinary intellectuality, erudition and self-reflexivity…subjective reconstruction. (p. 8).
Pinar makes an important distinction between the traditionalist and re-conceptualist views on education describing how the re-conceptualization of knowledge includes the integration of information, critical thinking, analysis and reflection. In connecting these elements, the teacher guides the learner to move beyond her\his present understanding and construct her\his knowledge and reach new understanding. In a re-conceptualist approach, curriculum becomes a dynamic, ongoing conversation where the teacher engages in reflection through communication with colleagues, students and others. The curriculum becomes reflective and responsive to the needs of students and society and is underpinned by both sound intellectual reasoning and thoughtful consideration of the patient and context.

Results from this study also indicate the values and assumptions that nurse educators bring to developing curricula and in their teaching practice. For instance, considering the issues involved in medication administration in the curriculum reveals the assumptions of nurse educators. A re-conceptualist approach enables educators to explore their assumptions and values related to teaching and learning and make visible their assumptions and theoretical approaches in developing curricula. Nursing educators using this lens would be able to examine and address the problems experienced by students learning the undergraduate nursing curricula, its impact on their learning and the care that students provide to patients. Giroux (1981) suggest that educators should abandon the ideological pretense of being value free. To acknowledge that the choices we make concerning all facets of curriculum and pedagogy is value laden is to liberate ourselves from imposing our own values on others. To admit as such means that we can begin with the notion that reality should never be taken as a given but instead has to be questioned and analyzed (p. 106).

Giroux (1981) makes an astute observation that teachers in developing curricula enter into an important curriculum journey, influenced by their values, biases and assumptions coupled with their own creativity and imagination. Selecting particular content includes making choices based on one’s assumptions and biases as other topics will be ignored or discarded. As my research indicated in the case of medication administration, nurse educators who were developing the curriculum focused solely on completing tasks on hand and did not consider student nurses understanding of the content or context. This valuing of homogeneity is at odds with the diverse learning needs of students. Similarly, I found that topics associated with
diversity or cultural sensitivity were relegated to being a minor objective or taught in a siloed approach in the curriculum. Similarly, the continued pervasiveness of a euro-centric model in nursing education is at odds with the diversity found in both the patient population and student body. Nurse educators by becoming aware of how their values and assumptions influence their decisions in developing curricula, they could then examine their decisions in a critical manner and develop nursing curricula with insight and humility, acknowledging the values and biases that influence their teaching and learn to teach in a more forthright and caring manner.

Both Pinar (2004, 2012) and Giroux (2004, 2007) posit that curriculum development is a dynamic, intersubjective and intrapersonal conversation where the teacher engages in ongoing self-reflection. The teacher considers varied viewpoints that emerge through dialogue and debate with students, colleagues and others and carefully considers each approach before deciding on particular content and how that content should be made available to others. Nurse educators by engaging students in dialogue, learn how students understand the content, the meanings and interpretations that students attach to their learning in order to guide students in their thinking and understanding of nursing. Student nurses embodied and experiential knowledge of nursing should also be considered in curriculum development. Another important element that could benefit the curriculum development process is that of inter-professional conversations, where nurse educators engage in dialogue and debate with other nurse educators, clinical nurse educators, education scholars, students and patients before arriving at a considered decision in developing undergraduate nursing curricula. Such conversations would allow both students’ learning needs in becoming a nurse and the needs of patients to come into sharper focus.

Nurse educators in adopting a constructivist approach to curricula development, design and implementation need to make visible two broad guiding principles. I reiterate two of these principles discussed in earlier chapters and they are; that learning involves an active construction of meaning by the learner, that learning of scientific knowledge occurs over time and acknowledge that students come with varied abilities; the second is that educators bring specific knowledge of teaching to their work in relation to transforming content so to enhance understanding, selecting appropriate teaching strategies to engage learners and the use of evidence biased teaching strategies on a consistent basis (Driver & Oldham, 1986).

Giroux (1981) adds that all knowledge including that of the teacher needs to be examined and challenged and “has to be situated in classroom social relationships that allow for debate and
communication’ (p. 106). Different perspectives and viewpoints are sought in discussion and
debate in the classroom and the factors that influence meaning and interpretation are examined.
Dialogue and debate are essential aspects in this approach and knowledge emerges from a
dialectical relationship between the teacher and student; where both engage in learning, posing
questions, reflecting and co-constructing meaning of the text under examination (Kincheloe,
2008). Truth is understood as provisional and search for understanding becomes an essential
aspect of learning. Nurse educators in engaging in a dialogical process of curriculum
development will be able to examine how concepts in nursing education such as pharmacology
are taught in the curriculum, assess students’ knowledge and understanding of medications and
scaffold content according to the learning needs of varied student audiences. In a dialogical
process, the curriculum does not pre-determine when students administer medications. Instead it
provides space for clinical instructors to tailor their teaching to meet the learning needs of
students, provides an opportunity for student nurses to integrate their knowledge of assessment in
the clinical arena, become comfortable in practicing their assessments prior to administering
medications.

Furthermore, nurse educators need to critically examine their teaching practice and
consider adopting a critical pedagogical approach. I discussed particular elements of critical
pedagogy in the Literature and Discussion chapter and will briefly review some important
features here. A nurse educator in adopting a critical pedagogical standpoint would engage
students in their learning through dialogue and debate, guide students in posing questions, enable
students to seek meaning beyond the superficial messages found in the textbook and examine
socio-political factors that influence their lives. In doing so, nurse educators empower students to
ask questions, challenge existing conditions that they encounter in practice and come together in
re-imagining a more social and equitable health care. Critical pedagogy enables educators to
think and contemplate beyond the obvious and is itself, a mode of intervention (Bertoff, 1990;
beyond the surface, the obvious and examine the socio-politico structures that influence or
constrain one’s actions. For instance, on instructing students about caring for a patient with a
stoma, nurse educators could enable students to think beyond the skill and physiological impact,
and consider the socio-cultural-economic impact on the patient and her/his family. Harden
(1996) suggests that nurse educators by adopting a Freirian approach to teaching, could uncover
the oppressive structures which confine and limit student learning and engage students in a
deep way to think about their lives, the patients in their care and society at large.

Furthermore, participant Paris mentioned that when she asked her nurse educator
colleagues about their understanding of critical thinking she encountered a range of
understandings of this concept from critical research to posing questions. Nurse educators need
to develop a robust understanding of critical thinking in their teaching in order to guide student
nurses in posing thoughtful questions. Critical thinking and problem solving abilities are
important priorities in nursing curriculum and nurse educators should guide students in
developing their critical thinking abilities. I found Freire’s description of critical thinking to be
very insightful especially when he states that critical thinking “was a way of offering a way of
thinking beyond the present,…beyond the immediate confines of one’s experience, entering into
a critical dialogue with history, an imagining a future that would not merely reproduce the
present’ (Freire as cited in Giroux, 2010a. p. 716).

Also, evaluation methods and grading practices in undergraduate nursing programs need
to be examined as they inevitably reflect particular world views and values and thus perpetuate
certain ideologies and perspectives. hooks (1994) suggest that teachers engage in dialogue with
students over evaluative criteria and states that a ‘dialogical grading eliminates this practice since
it allows students to gain some control over the distribution of grades and therefore weakens the
correspondence between grades and authority’ (p. 50). Evaluative assignments such as essays
with a reflective component enable student nurses to understand the issue's at a greater depth as
well as develop their critical thinking and reasoning skills (Bussard, 2014; Hatlevik, 2011;
Lasater, 2009; Naber, & Wyatt, 2014). This type of evaluative method also lends itself to
dialogical grading practices where nurse educators could engage students in discussion about
their learning.

Re-conceptualizing patient safety in curricula development

One of the main concerns raised by participants was nurse educators’ conceptualisation of
patient safety in curricula development, design and implementation. For instance, participants’
concerns related to medication administration in the curriculum. Patient safety is described as
“minimizing a patient’s exposure to hazards and near-misses and likewise, reducing the risk of
educators (Chenot & Daniel. 2010; Debourgh & Prion, 2012; Ginsburg, Castel, Tregunno &
Norton. 2012; Girdley, Johnsen & Kwekkeboom, 2009; Gregory, Guse, Dick & Russell, 2007; Lukewich, et al. 2015; Onge, & Parnell, 2015; Tella, et al., 2014), subscribe to a similar understanding of patient safety. I recommend that nurse educators develop a more advanced, nuanced and progressive approach to integrating patient safety in developing and implementing curricula and in their instructions. Concepts related to safe patient care such as oxygenation, medication administration etc. should be considered during the development of curricula and in how that content is sequenced and taught in the curriculum. Nurse educators should address patient safety concepts explicitly in a coherent and systematic manner in the curriculum and in their instructions. Also, nurse educators need to consider students’ understanding of this concept more deeply and as it relates to each aspect of the curriculum. Furthermore, nurse educators should also consider the variability amongst student nurses' learning needs, their prior knowledge and practical experiences of nursing. Nurse educators should also acknowledge their particular areas of expertise and areas of improvement and seek out resources to guide them in their learning journey.

**A Re-conceptual Approach to Instruction in Nursing Education**

A re-conceptualist approach to instruction would enable clinical nurse educators to make decisions about when students should begin administering medications based flexibly, on their observations and knowledge of student learning in the clinical arena. Nurse instructors could then tailor their teaching to meet the learning needs of students. How students learn, understand and integrate each topic in their practice needs to be assessed in a coherent and timely manner. Similarly, keeping patient safety as the first priority, my results suggest that medication administration by a student nurses should be considered only once student nurses complete required course work in anatomy, physiology, pathophysiology, pharmacology, possess a thorough understanding of assessing a patient and integrating data. Also, in my observations of students in the clinical area and from anecdotal accounts I suggest that medication administration should be considered only after the student has practised in the clinical area for at least a minimum of three hundred hours and demonstrated sound knowledge of important underlying concepts.

A re-conceptualist approach to instruction would enable nurse educators to assess and choose appropriate teaching methods to accommodate all types of learners. For example, participant Adele made an important observation that some nursing students have learning
disabilities, and yet accommodations for their individual learning needs are not taken into account. Instead, all students tend to be taught in the same way.

Nurse educators (Bieta, 2013; Brown, Kirkpatrick, Mangum, & Avery, 2008; Cook 2005; Diekelmann & Scheckel, 2004; Doane & Brown 2011; Lewis, 2014; Silva, 2012; Tanner, 2006; Webber, 2002) suggest that nurse educators should address learning experiences that are relevant to the practitioner thereby enabling students to make meaningful connections between concepts learned in the classroom and their practice. Pedagogical practices such as engaging students in small group work, where dialogue between and amongst students demystifies the traditional authoritarian role of the teacher and provides students with a social context that stresses social responsibility. Also, small group work enables students to act collectively in the process of learning and teaching. Knowledge becomes a vehicle for dialogue and analysis and a basis for new relationships. Nurse educators should move towards making meaningful connections between the content and actual nursing practice through discussion and dialogue in the classroom.

7.2. Research in Nursing Education.

On reviewing the literature on research in nursing education, I found a paucity of studies, most of which seemed to focus on particular teaching techniques or technologies and only a few studies (Diekelmann, 2001, 2004) related to developing curricula or pedagogy in nursing.

Broome, Ironside, and McNelis (2012) conducted a cross-sectional survey of schools of nursing in the United States. The purpose of the study was to examine the current state of research in nursing education and teaching in nursing schools in the United States. The survey was sent to approximately six hundred and seventy Deans of nursing in undergraduate and graduate programs. The response rate to the survey was low with only twenty-one (3.1%) respondents returning the survey. Four of the twenty-one respondents stated that none of their nurse faculty conducted research in education and a majority of respondents reported that fewer than 10% of nurse faculty conducted research in nursing education. Furthermore, clinical nurse faculty were not involved in conducting research in nursing education. The three primary reasons provided for the paucity of research in nursing education are lack of protected time to develop and conduct research, lack of faculty interests in researching issues related to nursing education and lack of funding related to education research. I suggest that nurse educators need to be more involved in conducting educational research beyond their specific focus in nursing as the
education of future nurses requires more investigation. Also, nurse educators need to engage in reflecting on and problematizing their own teaching as a way to deepen their knowledge of teaching (Cochran-Smith, 2003; Lytle & Cochran-Smith, 1992) as well as contributing in important ways to scholarship of teaching in nursing. Moreover, nurse educators teaching in the classroom and clinical nurse instructors could collaborate in developing research questions and conducting research in order to improve teaching in nursing. Richardson (2003) notes the importance of research in education so as to build a theory of teaching that could guide nurse educators. An education program for nurse educators would provide a focus for research to be carried out by nurse educators to that was specifically relevant to nursing pedagogy.

Similarly, nurse researchers (Evans, 2006; Ferguson, 2005; McAllistor, 2005a; Walker, 2009) suggests that nurse educators engage in re-examining their teaching practice in order to bring evidence-informed practices to developing curricula and pedagogy in their teaching practice. I concur with those teacher educators (Cochran-Smith, 2003; Cochran-Smith & Lytle, 1999) who encourage teachers to pose questions from their teaching practice and connect their research efforts with others in the field and to larger intellectual, social and political issues. I acknowledge that developing a research program focusing specifically on the scholarship of teaching in nursing is a difficult endeavour given the lack of funding; however conducting research in the education preparation of future nurses is an important contribution to society at large.

Areas of future research: In conducting this study, I found particular areas that warrant more examination. For instance, I briefly mentioned my observations about how and when participants seemed to transition from a nurse to becoming a nurse educator. Four participants with graduate degrees in education seemed to self-identify as a nurse educators. During interviews, these participants referred to themselves as educators and shared many insights on teaching in the clinical arena. The process of becoming a nurse educator and factors that enhance or inhibit the transition process needs to be examined in order to inform the development of future nurse educators. Again, I found that literature in teacher education has substantial information on the transition process of teachers and teacher educators that could provide important parallels insights for nurse researchers to consider. Replication studies in nursing education that focus on how nurse educators develop their pedagogical content knowledge would also inform and enhance the teaching practice of nurse educators.
Overall conclusions of this Study

The purpose of this study was to explore the pedagogical practices of clinical nurse educators and the challenges that they encountered while teaching in the clinical arena. All twelve participants taught in undergraduate nursing programs in a large metropolitan city in Ontario, Canada.

Grounded theory methodology forwarded by Charmaz (2010) was used in this study design and semi-structured interviews were conducted with each clinical nurse educator participant. Coding strategies forwarded by Corbin and Strauss (2008, 2015) and Charmaz (2010, 2011) such as constant comparison and theoretical sampling were used to analyze the data. Study results were further analysed using a constructivist approach to learning and a critical pedagogical approach to education. Initially, five main concepts emerged from the data and these concepts were further conceptualised to form the study’s central concept. The substantive theory that emerged from the data is, *The pedagogical practices of clinical nurse educators and the navigation of constraints in complex educational institutions.*

The results from this study provide a deeper and broader understanding of teaching in the clinical arena and sheds light on the contribution of clinical nurse educators to preparing students in becoming nurses, a topic that is missing in nursing education literature. The results reveal the challenges that participants encountered while teaching in the clinical arena and the culture of teaching in nursing education. The results also showcase the importance of formal education for nurse educators in order to improve curricula development and nursing pedagogy.

The results from this study led to two important recommendations, an education program for all nurse educators so as to improve curricula development and pedagogy in nursing education and the second recommendation provides a re-conceptualist approach to developing undergraduate nursing curricula.
8. References


Canadian Association of Schools of Nursing (CASN). (2010). Environmental Scan on doctoral programs.

Canadian Association of Schools of Nursing. (2014). *Registered Nurses Education in Canada Statistics*.


Charmaz, K (2010). *Constructing grounded theory: A practical guide through qualitative Analysis*. Sage publication LTD.

College of Nurses. (2009). *Supporting learners: Practice Guideline*
College of Nurses (2002). *Professional Standards*.
Daniels, H.; Lauder, H.; & Porter, J. (2009) *Knowledge, Values and Educational Policy. Critical Perspective on Education*. Publisher: Routledge,
Davidson, K. M. & Rourke, L. (2012). Surveying the orientation learning needs of clinical
nursing instructors. *International Journal of Nursing Education Scholarship*, 9(1), 1-11.


hooks, b. (1994). *Teaching to transgress: Education as the Practice of Freedom.* Publisher Routledge.


Ironside, P. (2015). Narrative pedagogy: Transforming Nursing Education through 15 years of research in Nursing Education. *Nursing Education Perspectives*. 36(2). 83-88.


Lofmark, A.; Carlson, M.; & Wikblad, K. (2001). Student nurses perception of independence of


McKeon, F; & Harrison, J. (2010). Developing pedagogical practice and professional identities of beginning teacher educators. *Professional Development in


Silva, M. (2012). The scholarship of teaching as science and as art. *Journal of Nursing Education.* 51(11), 599-601.


Appendix 9.1- Introduction letter to potential participants

Anita Jennings. PHD(C)
Department of Curriculum, Teaching and Learning
OISE- University of Toronto,
Toronto.
anita.jennings@utoronto.ca

March 4th, 2014

Dear Clinical nurse instructor,

   My Name is Anita Jennings and I am a PHD candidate in the Department of Curriculum, Teaching and Learning at OISE-University of Toronto. I am conducting a qualitative grounded theory study and studying the teaching practices of clinical nurse educators in the clinical arena.

   The name of the research project is-How do clinical nurse educators approach teaching undergraduate nursing students in the clinical arena?

   The purpose of the research study is twofold; to provide a comprehensive understanding of the values and knowledge that guide clinical nurse educators in their teaching practice; and to explore the challenges that clinical nurse educators encounter while teaching in the clinical environment.

   You will be asked to participate in two interviews at two separate times. Each interview is an individual interview. The interview will last for approximately 1-1/2 hours. The location of the interview will be mutually agreed upon. All information collected will be confidential and individuals will not be identified in any reports resulting from this study.

   Your participation in this research study will provide a contribution to the literature on teaching in nursing in the clinical arena. Research about nursing education in Canada is sparse at best and there is almost no research on teaching in the clinical arena. If you would be interested in participating in this study, please complete the following contact information.
Name-________________________________________
Contact telephone number _______________________________
Contact email ______________________________________

Screening questions

1) Do you have a degree in nursing? YES\NO

2) Are you currently teaching or have recently taught in an undergraduate nursing program in the clinical setting? YES\NO

3) How long have you been teaching in the clinical setting? Please check the correct Response.
   Less than 2 yrs. 3-4 yrs. 4-5 yrs. More than 5 years.

4) In which year are you teaching undergraduate nursing students in clinical?
   YR 1 YR 2, YR 3, YR 4.

Thank you for considering this invitation.

Regards Anita Jennings.

Contact information if you have questions:
anita.jennings@utoronto.ca

For more information about your rights, you could contact the Office of Research Ethics at ethics.review@utoronto.ca or 416-946-3273.
Appendix 9.2. Information letter and informed consent form

Anita Jennings, PHD(C)
Department of Curriculum, Teaching and learning
OISE- University of Toronto
Toronto
UFT REB APPROVED PROTOCOL #29727

anita.jennings@utoronto.ca

January 21st, 2014

Dear Participant,

My Name is Anita Jennings and I am a PHD candidate in the Department of Curriculum, Teaching and Learning at OISE-University of Toronto. I am conducting a qualitative grounded theory study and studying the teaching practices of clinical nurse educators.

The name of the research project is- How do clinical nurse educators approach teaching undergraduate nursing students in the clinical arena?

The purpose of the research study is twofold; to provide a comprehensive understanding of the values and knowledge about teaching and nursing that guide clinical nurse educators in their teaching practice; and to explore the challenges that clinical nurse educators encounter while teaching in the clinical environment.

The specific research questions that inform the study are:

1) How do clinical nurse educators approach teaching undergraduate nursing students in the clinical arena?

2) What types of challenges do clinical nurse educators encounter while instructing undergraduate nursing students in the clinical environment?

Your participation in this study is entirely voluntary. In other words, you may decline to answer any question or participate in the interview without negative consequences. You have the right to withdraw from this project at any time.

All information collected will be confidential. The researcher will anonymize all data and identify each participant using a pseudonym only. Individual participants will not be identified in any reports resulting from this study.

What will I be asked to do?
You will be asked to participate in 2 interviews at two separate times. Each interview is conducted on an individual basis. The interview will last for approximately 1-1/2 hours and will be conducted at a time and location convenient to you.

**What are the risks and benefits of participating?**

There is no specific benefit to participating in this research study other than knowing that you are contributing to the research literature on teaching in nursing. Research about nursing education is sparse in Canada and research on teaching in the clinical arena is close to nonexistent, making it an important area to study.

There are also no known risks involved in your participation.

**How will the information be used?**

The data obtained from interviews will be analyzed and written up as a study. Only the researcher and thesis supervisor, Professor Clare Brett will have access to the data. Confidentiality will be maintained at all times. Pseudonyms will be used at all times for all the data. Neither you nor your institution will be identified in any way.

If you choose to withdraw prior to the first interview, all screening data will be destroyed. After the first interview and on transcribing the data, each participant will be given a pseudonym. Thereafter, all data will be retained and used in the analysis as delinking data will not be possible.

I will keep the audio recordings and transcriptions of the interview in a locked storage cabinet. The information will be destroyed five years after the completion of the study. No one other than my supervisor and I will have access to the data.

I will use the data from this study to write scholarly papers on clinical teaching which will be submitted to academic journals for publication and to nursing conferences for presentation.

The reporting of findings will take place in late 2014-2015. I will contact each participant with the summary results of this study.

**What do I need to do to participate?**

Please read this information letter and ask any questions before you consent to participate. If there is anything you do not understand, or you have any questions later, please contact me at: jenningsa@rogers.com

Or contact my thesis supervisor: Professor Clare Brett
Email: clare.brett@utoronto.ca
Phone: 416 978-0132.

For more information about your rights, you could contact the Office of Research Ethics at ethics.review@utoronto.ca or 416-946-3273.
Consent Form

Name: ……………………………

I have read the attached letter and agree to be part of the research study-How do clinical nurse educators approach teaching undergraduate nursing students in the clinical arena?

I agree to let Anita Jennings use the data for purposes of research and to quote from the interviews.

Signature: ……………………………

Date: ………………………………

Please indicate the email address (if any) you would like us to use.

Email address: ……………………………
Appendix 9.3. Interview Guide Sample

1st Interview

Demographic information
1. How many years have you been practicing nursing?
2. How many years have you been teaching nursing?
3. Are you currently teaching in a BSCN nursing program or other nursing program?
4. How often you teach clinical?
5. Could you please tell me briefly about your education background? What nursing/non nursing degrees do you have?

Research Question 1- How do clinical nurse educators approach teaching undergraduate nursing students in the clinical arena?

Prompts related to above research question

Teaching in the clinical arena
1. Could you describe a typical day in clinical (making student assignments, conference)?
2. As you think about your day in clinical, could you describe you’re teaching moments.
3. Could you tell me how you learnt to teach nursing? (formal\seminars\textbooks).
4. Could you describe how you prepare to give feedback to the student? Formative and summative)

Research question
2) What types of challenges do nurse educators encounter while instructing undergraduate nursing students in the clinical environment?

1. Have you encountered problems whilst teaching in clinical?
2. Could you describe the sources of the problems?
3. When faced with the problems, how do you cope, how do you manage the problem?
4. Tell me how you learned to handle such problems?
5. Who was most helpful to you? When, how, and how has this helped you?

Ending question-
Is there anything you like to ask me?
Interview 2

1. Could you explain to me what informs\guides your decisions in relation to assigning students
   1a. When to help a student
   1b. how to help a student
2. Could you describe how changes in the course come about? Could you make suggestions and is your voice heard in making changes to the clinical course.

Questions posed from subsequent interviews

1. Could you describe when you first began teaching?
   Describe the context, number of students. How you felt, what you thought?
2. Could you explain how did you come to “know” the how and when of helping the student? How do you know which student needs assistance- what guides and\or informs you’re thinking and decision making?
3. When did you first experience or noticed (race\gender\ethnicity) issues in your teaching practice? Could you describe the events that led up to it?
4. What is your understanding of the term hidden curriculum? Could you provide me with an example?

Ending question-
3. Is there anything you like to ask me?