AN EXPERIENCE TAKING PATIENT ASSIGNMENTS WHILE IN THE TEACHER ROLE

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PURPOSE

As an instructor with six third-year students, I took patient assignments to obtain some insights regarding (1) the effects this might have on my self-perception in the teacher role and (2) the value which students might perceive it had in enhancing their learning.

BACKGROUND

Interest in doing this stemmed from an experience while working the previous summer with a smaller group of students. I observed a student perform a moderately complex dressing for a patient on his infected, bilaterally amputated lower limbs. During her performance, I could well anticipate how both technical manipulations and patient support could be accomplished and was able to give guidance to the student when needed.

Since no student was assigned to this patient a few days later, and since the dressing involved equipment I had never actually used myself, I was stimulated to do it. This was most enlightening!

Technical manipulations were radically more difficult to perform than when I had "done" them in my mind as an observer. As a result, there were real feelings of frustration on my part, and it was very difficult to give any effective support to the patient. I found that this experience greatly changed the perspective in which I was able to discuss this aspect of patient care with the student. It seemed to break down some of my own authority role perceptions, to enable me to share more than tell, and to sense increased rapport with the student.

CHARACTERISTICS OF THE PROJECT

In April, 1973, I was an instructor with students during their one month continuous clinical experience at the conclusion of their third year. This period seemed to present an ideal time to try this approach in an enlarged way. The objectives for the students involved increasing their independence in the application of previous knowledge and skills, therefore decreased direct teacher involvement was desirable. The medical ward for this experience was one with which I was familiar, having been an instructor there during the year. The staff was

known to be receptive to becoming involved in guiding students' patient care activities, as well as creating a warm, flexible milieu for students and instructor. The nursing staff was composed of two teams, the team leaders having responsibility for patient care assignments.

It developed that two students in the group had previously been on this ward and that I had been an instructor with five of the six students at some time during the previous year. Therefore, I had knowledge of their general performance ability and had established fairly good relationships with them. Two of the staff nurses were also former students with whom I had worked.

As this project was not planned as a formal one, explanation to staff and students was very informal. After explaining to the Head Nurse my general purpose, I told the students as part of their orientation for the April clinical experience that I planned to take a patient assignment. This was related to their objective of increased independence and to my desire to give patient care. I told them that I would probably want some feed-back from them as to how they found this worked out.

With the team leaders I had freedom in deciding when I would take a patient assignment and great flexibility in which patients I would care for.

RESULTS

SITUATIONAL ROLE CONFLICTS

Since I had planned to subordinate my undertaking to the overall experience for the students if these should conflict, a number of things were found to influence the number of days I took a patient assignment, the patients selected, and patient continuity. The types of situational conflicts involved teacher role responsibilities related to (1) my availability to students when the ward was extremely busy at the beginning of the experience and there were heavy demands on staff; (2) patient availability to me later in the experience when there was a large staff to patient ratio, with students also desiring to increase their patient case load; (3) attendance at a faculty meeting which conflicted with clinical time; and (4) time involved giving mid-term evaluations to the students.

These teacher role responsibilities were much more of a factor in the evolution of the project than had been anticipated.

The result was that I took a patient assignment nine of the fifteen days. This involved one to five patients in each assignment, usually three to four. Continuity of patients was usually two days, though some patients were cared for for three days, and some for only one.

EFFECTS ON SELF-PERCEPTION IN THE TEACHER ROLE

One of the most striking effects was my feeling of apprehension in losing from the students the respect for competence which the teacher role had protected. For although incidental direct patient care had been given previously in the teacher role, this patient care role substantially increased my performance competence requirements and so my vulnerability. This feeling of threat did diminish during the experience.

I found myself having much more empathy with the students in planning and implementing care. Though it was not specifically planned that way, I cared for some of the same patients that students had cared for. In these situations, particularly, I could understand their frustrations much better and felt more credible in discussions with them related to patient responses, bureaucratic problems, nursing and health team relationships, applying theory in practice, and mere physical fatigue's inhibitory effect on carrying out plans.

It was also very interesting to discover my *modus operandi* in actually approaching and giving patient care in this environment. The approaches and habits which I had developed as a staff nurse were more naturally performed, such as initiating discussion with other health team members. Things I had encouraged and assisted students to do for a number of years but had not done previously in a consistent manner in practice were extremely difficult to do, such as making a nursing care plan on the Kardex. These things I had to consciously make myself do because I knew I should. Credibility was certainly one of the motivating factors.

STUDENT RESPONSE

From informal comments throughout the experience I felt a positive response from students to my taking a patient assignment. The following question was then included in the written evaluation of their April experience: "From the point of view of your own learning, what were the advantages and disadvantages of the instructor taking a patient care assignment?"

No disadvantages were mentioned in their responses. All students made enthusiastic comments related to this approach encouraging their own problem-solving and independence and increasing their integration into the nursing team.

Four students made comments indicating an increased feeling of rapport with the instructor, such as, "took away from student status", "less tension as she was not just checking up", "she felt more like

a member of the team and was yet quite available for help when we needed her. I know the staff really noticed this and appreciated it".

Comments related to patient care role modeling were made by two students: "I could see how she managed care and nursing notes"; "was able to observe care and learn by that".

DISCUSSION

ROLE MODELING

Marlene Kramer used modeling as a major teaching approach in studying ways of developing and enhancing teaching strategies(1). She and her colleagues had observed low satisfaction from students in a general medical-surgical setting in which there was a lack of nurse role models who had enthusiasm for nursing. From her previous research, she was also concerned with role conception of baccalaureate students and its evolution in the work setting. In the light of her extensive review of modeling behavior in other fields, she felt its potential was not being tapped in nursing. Kramer's field research was done with first-year students in a ten-week experience. The instructor was a former faculty member who was known in the setting in both instructor and staff nurse roles. Among the major results were the positive attitudes of the students toward their clinical experience and their increased integration into the nursing team in seeking assistance in patient care(2).

Though there were similar desirable student responses in my undertaking, the project was too informal to ascertain to what degree these were attributable to my taking patient assignments. I feel similar responses had been achieved two years previously in this same experience and setting by my physically leaving the ward for long periods during the day.

ROLE CONFLICTS

To me, the level of students, the ward staff and environment, and the continuous nature of the experience were key to attempting the project. I would feel the role conflicts which I found would be greatly increased in shorter concurrent experiences with younger students. The judgement of when and how much responsibility to take for patient care seemed quite important in reducing role conflict. Once I made these decisions, there was minimal role conflict felt.

INSIGHTS INTO OWN APPROACHES

Some of the insights into my own approaches to nursing care might have been gained and the approaches improved upon by giving patient care for a period of time without being in a teacher role. This would have eliminated the teacher role responsibility conflicts. Also, it probably would have diminished the initial feeling of threat if patient

care had then been given with students present. However, I do not think I would have gained as much insight into myself in the teacher role.

VALUE OF DUAL ROLE

The unique value of trying the dual role seemed to be the increased feeling of cooperation in learning in my own and the students' perception. In my own stage of development as a teacher, it greatly assisted me in working through my desired role identification and behavior. Helen Glass has related this in her description of the ideas of Carl Rogers,

> . . . who stresses the teacher's need for congruence. This involves the teacher being the person that he is, and being openly aware of the attitudes he holds. Thus, he becomes a real person in the relationship with his students. His expectation is that a climate in which the teacher is his real self will encourage significant, self-reliant, personal learning on the part of the student, and that there will be a reciprocal effect on the teacher(3).

There are many ways in which a teacher can try to diminish inhibitory role barriers in teacher-student communication. The approach tried would seem to have real value as one way of fostering person-to-person dialogue in order to facilitate positive attitudes toward learning *per se* and toward patient care, as well as creating an atmosphere more conducive to cognitive and psychomotor learning. In Glass's terms(4), it seems to be a "freeing" teaching strategy as opposed to a "restrictive" one.

In Glass's study, she noted the lack of innovative teaching approaches — the predominant strategy being "coaching" before, during, and after patient care(5). The modeling strategy does seem a viable one in selected situations. It would also seem to assist the teacher in developing and teaching the social-interaction skills which Glass sees as crucial to survival in agencies and which there was little opportunity for in the programs she studied(6).

In Kramer's findings related to baccalaureate students' role conception, she poses the question as to whether the teacher role needs to be perceived by students as less idealistic and more in line with problems encountered in the real work situation(7). She found that graduates who experienced the greatest role deprivation in the hospital work setting were those graduates whose primary role models had not changed from instructors to service personnel, or were service personnel who had recently left the work setting. Indeed, most of these graduates were making plans to go into fields other than nursing(8). Again, the modeling approach would seem to be one

way of fostering a student's role conception which would be less vulnerable and frustrating when confronted with the pressures and problems of the actual work situation.

REFERENCES

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2. *Ibid.*, pp. 65-67.
3. Helen P. Glass, "Teaching Behavior in the Nursing Laboratory in Selected Baccalaureate Nursing Programs in Canada," Ed. D. dissertation, Columbia University Teachers College, 1971, p. 25; in reference to Carl R. Rogers, *Freedom to Learn* (Columbus, Ohio: Charles E. Merrill Publishing Co., 1969), p. 123.
4. Glass, *op. cit.*, p. 23.
5. *Ibid.*, pp. 284 and 286.
6. *Ibid.*, pp. 282 and 292.
7. Marlene Kramer, "Role Models, Role Conceptions, and Role Deprivation," *Nursing Research* 17 (March-April, 1968) p. 115.
8. *Ibid.*, pp. 118-119.

RESPONSE TO "AN EXPERIENCE TAKING PATIENT ASSIGNMENTS WHILE IN THE TEACHER ROLE"

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Miss Gendron deserves credit for examining her role as a teacher that led her to explore an area of interest to teachers of nursing. She attempts to study "the effect of the teacher's taking a patient assignment on the students' learning" and then draws some inferences related to the notion of role modeling as a teaching strategy.

One would not argue that role modeling may be an effective means of teaching nursing. In the past, students of nursing were introduced to role models in the traditional hospital schools. The environment in which they learned to nurse was populated with many graduates of the same school. Thus the model of what she was to become was evident to the student as she learned within the hierarchical structure of the hospital system. A criticism of the product of these schools was that there was little variation in the graduate's approach to nursing. Miss Gendron notes that "the modeling strategy does seem a viable one in selected situations." If this is so, then the question arises, "What are these situations?"

Whether or not the teacher includes role modeling as a strategy would depend on the conditions of learning she wishes to provide. Miss Gendron found that one approach, taking a patient assignment, provided a condition where she was able to share her knowledge with the students. This episode, however, raises a variety of questions about the teacher's role in the clinical field.

Rather than pursue the notion of the role model, it might be useful to question what the author discovered as she studied the problem of taking a patient assignment while in the role of a teacher. In the limits of the space available, it is possible to respond to only one of the situations described in the paper.

Miss Gendron noted a discrepancy between her assessment of a particular patient situation on two different occasions. When she guided a student who was caring for a patient with bilateral amputated legs, the author anticipated how the student could give support to the patient while manipulating the technical equipment. Later, the author undertook the care of the patient by herself and discovered that the "technical manipulations were radically more difficult than she had anticipated," she felt frustrated and unable to give "effective support" to the patient. The results of this experience were, however, that the teacher was able to "share more than tell", she sensed greater rapport with the student and her perception of the teacher as an authority was changed.

From this experience, what are some of the implications for the teaching of nursing? It would seem that the teacher, as an observer, obtained an incomplete picture of the complexity of the patient's nursing care. What were the teacher's sources of information prior to choosing this patient for the student? What information was gained from the patient? What information did the nursing staff contribute? In other words, how does a teacher of nursing gather information about the patient? Further to this, how does this information influence the teacher's perception of the patient's nursing care?

Having selected the student to care for this patient, one can only speculate on how the teacher continued to gather information. If the instructor was with the student while she cared for the patient, then one might question how the teacher was participating in the patient's care. Was she a participant-observer, thereby assisting with the technical manipulations and/or talking with the patient? If this were so, it might indicate that two nurses were required to manage the patient's care. On the other hand, perhaps the teacher was in and out of the patient's room and was only getting a selective view of what was happening. Of most importance, what opportunity was given to

the student to share the information she had gained in caring for the patient? How would the teacher describe the student's behavior during this experience? What opportunity did the student have to study her own performance? What part did the patient play? What did the teacher and student learn about nursing this particular patient? How was the conclusion reached that effective support was given to the patient?

Answers to these questions were not found in Miss Gendron's paper. If, however, the teacher had the answers, it would seem unnecessary to care for the patient herself in order to discover the complexity of the technical aspects of the care, or to recognize the frustration of the student in caring for the patient.

There seems to be little doubt that a teacher of nursing needs to be involved in patient care if she is to be a resource person for the students. Miss Gendron discovered that taking a patient assignment conflicted with her responsibilities as a teacher. Exploring alternative ways of teacher involvement in patient care would be an interesting topic for future discussions.