NURSING PAPERS

WINTER 1974-75

TAKING PATIENT ASSIGNMENTS WHILE IN THE TEACHER ROLE

IDENTIFICATION OF LEARNING NEEDS DURING PRACTICE

FREEDOM TO LEARN

Volume 6, No. 4

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Moyra Allen, *Editor*
Vivian Geeza, *Managing Editor*

Nursing Papers is published quarterly by the School of Nursing, McGill University, 3506 University Street, Montreal, P.Q. H3A 2A7, Canada. Faculty in university schools of nursing and nurses with similar concerns are invited to contribute manuscripts, letters and ideas. We are particularly interested in articles assessing problems, posing questions, describing ideas and plans of action in research, education, administration and practice.

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NURSING PAPERS
Volume 6, numéro 4
Hiver 1974-75

Moyra Allen, *rédacteur en chef*
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EDITORIAL

After weathering production difficulties with this Winter issue, we are able to report that the Spring 1975 number is now in press. The Committee on Nursing Papers has established the following schedule of publication:

Issue	*1975*	*Subsequent years*
Spring	June 1	February
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Fall	October 1	August
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On the debit side of the ledger, however, inflation and a longer average length for each issue have been taking quite a toll. Printing costs for the first four issues of the magazine were $2102; for the last four, $4178. For six years, it has been our policy to retain the original price of one dollar per copy. Now, this amount won't even pay the printer. While printing costs have risen steeply in the last year, we have other expenses as well. **Nursing Papers** must be prepared for printing, proofread, addressed, mailed and sometimes invoiced. Several out of print issues have been reprinted as a service to libraries and individuals who require a complete set, a service we wish to continue.

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Letter

To the Editors:

The article on The Bachelor of Nursing Program at The University of Calgary was written by me. I would appreciate it if this correction is included in your next issue of **Nursing Papers.** I am sorry that this byline was not included when we sent our statement of the Program.

Sarla Sethi
Assistant Professor
School of Nursing
University of Calgary

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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.

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4. Glass, *op. cit.*, p. 23.
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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.

IDENTIFICATION OF LEARNING NEEDS DURING PRACTICE IN A DAY CARE CENTER

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I have long had a strong reaction to the notion, sometimes rather cynically expressed, "If you can't do it, teach it". In order to teach a subject, one must be thoroughly knowledgeable about it. Yet there is the problem for teachers of maintaining the level of their knowledge and skills. Essential reading about current developments in a subject can certainly keep one informed. But lacking the opportunity to test and apply this knowledge may cause a deficit in understanding. As a teacher of nursing, the teacher's remoteness from the actual giving of patient care except as incidental to the students' learning is a matter of concern to me.

The clinical teacher, according to Smith, "must be both practitioner and teacher — a duality of roles which requires a disciplined command of theory, facility in its application, and ability to help others develop knowledge and skills(1). Can a teacher retain her expertise as a practitioner when her opportunities for testing and applying theory are limited? And, if these skills are consequently diminished will it also limit her in assisting the student to develop nursing skills? Such patient contact as the teacher has is usually related to helping the student assess possible solutions to the patient's problem. Rarely is the teacher involved in helping the patient with his experience of illness and treatment. If the clinical instructor does not have the opportunity to use her own nursing skills does she retain these skills? And, is there any possibility that she will value them less highly and thus lose some of her ability to help students gain these same skills and values? Smith also states:

> One difficult aspect of clinical teaching involves helping students deal with situations which may run counter to natural human inclinations . . . such as, those who are despondent, helpless, anxious, disfigured or malodorous. Compassion is the bridge which can carry the nurse's skill and concern to those who need her most(2).

I wonder if the clinical instructor loses some of these qualities of compassion because of her infrequent exposure to patients and then is unable to help students provide care for patients with repugnant symptoms. Compassion is an essential component of high quality

ADAPTED CRITICAL EVENT RECORD CARD

Date:

Diagnosis:

Phase of Patient Care:

Nature of Decision-Making Situation:

Category of Learning Need:

Cognitive .....New Learning .....Re-Learning .....
Cognitive Affective.....New Learning .....Re-Learning .....
Psychomotor .....New Learning .....Re-Learning .....

Identify Content Needed:

How was situation disposed of?
(a) Were the needed skills acquired at the time?
(b) If acquired at the time — how? (e.g. teaching from doctor)
(c) Was other help sought? (e.g. literature)

My Interpretation:

Figure 1.

care. The teacher is held accountable for the quality of care given by her students. It seems conceivable that she may not be able to promote this quality of care when she has not been responsible for patient care over an extended period. Indeed, her potential for creativity in considering high quality care may suffer. Consideration of this was another reason for wanting more nursing practice.

Consequent to this thinking, I felt the need for continuing education in the area of practice. As a teacher, I had not had direct responsibility for patient care for thirteen years. Nor had I ever practiced in a day care centre either with individual patients or as a leader in therapeutic groups. Development of knowledge and skills needed to give care to out-patients in order to guide students in developing an understanding of this concept seemed essential, especially in view of the present trend to keep patients functioning in the community. My long-term goal was to improve my teaching.

METHOD

The setting in which the experience took place was a psychiatric day care centre of a large university hospital. Arrangements to work as a staff nurse, for four days a week, for a period of four weeks, were made with the agency. In addition to nursing intervention in the case of individual patients who were having difficulty with groups, activities included participation in interdisciplinary planning, acting as co-leader in therapeutic groups which included sensitivity groups, problem-solving groups, and insight-gaining groups.

TABLE 1

MAJOR CATEGORIES OF LEARNING

Category	No.	%
New Learning	33	66
Re-Learning	17	34
Total	50	100

My first concern was how to keep an accurate record of what I learned so that there might be some objective way of assessing whether the experience had been useful and also to have a file of new learnings and incidents which could bring new vitality to my teaching. It appeared that the Critical Event Record Card used in a study by Jones and Parker(3) would, with some revisions, serve this purpose. The major revisions were two:

1. Adding a Re-Learning category to New Learning.
2. Adding the affective category to cognitive learning.

The card as revised and used is reproduced in Figure 1.

Events were recorded on the Critical Event Record Card as soon as possible after the learning situation had occurred. Use of the Critical Event Record Card as a tool was based on assumptions similar to those that were used with students in the Jones and Parker study. These assumptions were:

(1) I had sufficient practice in self evaluation to perceive gaps in my own knowledge.
(2) Reporting would be accurate.

Two differences in my use of the cards were:

(1) I was the subject as well as the experimenter.
(2) I could make an immediate judgment as to whether the situation had required learning or re-learning and thus how it should be recorded.

ANALYSIS OF RESULTS

Cards were sorted in terms of whether the experience was new learning or re-learning and the results were tabulated (see Table 1). These situations might have occurred in any phase of patient care (assessing, planning, giving or evaluating) and in any of the learning sub-categories of cognitive, cognitive affective or psychomotor.

TABLE 2

PATIENT CARE LEARNING

Phase of Patient Care	New Learning		Re-Learning		Total	
	No	%	No	%	No	%
APGE	1	2			1	2
APE			2	4	2	4
AP			1	2	1	2
PG	2	4			2	4
P	4	8	1	2	5	10
GE	8	16	6	12	14	28
G	11	22	7	14	18	36
E	7	14			7	14
Total	33	66	17	34	50	100

A—Assessing Patient Care
P—Planning Patient Care
G—Giving Patient Care
E—Evaluating Patient Care

Although the majority of learning events were new learning, one-third of the needs were things previously learned which had to be re-learned. This indicates to me that a teacher not only has to continue learning but may have to re-learn skills which she has not been using.

Of the 50 events, 33 new learning and 17 re-learning, the highest percentage occurred in the Giving, Evaluating categories. Only a minor percentage fell into the Assessing, Planning categories (Table 2).

In looking at the first 5 categories in this table all of which involve the assessing and planning of care, one sees that they add up to only 22%, while the final 3 in which the events related to either giving or evaluating care are 78%. It should also be noted that, of the categories which make up 22% of the total 3 also include giving and evaluating care.

Further categorization of the events in terms of the domain of learning is shown in Table 3. In relation to the sub-categories, the largest number of events occurred in the cognitive area. The cognitive learning needs were in relation to philosophy of day care, new drugs and new patient approaches, individual and group behavior patterns and team functioning in a psychiatric day care centre. Cognitive affective learning needs which were concerned with dealing with reactions that were inhibiting functioning, constituted 14%, all in the re-learning area.

TABLE 3

SUB-CATEGORIES OF LEARNING

Sub-Category	New Learning		Re-Learning		Total	
	No	%	No	%	No	%
Cognitive	32	64	10	20	42	84
Cognitive Affective			7	14	7	14
Psychomotor	1	2			1	2
Total	33	66	17	34	50	100

Data were also examined with a view to determining whether recent developments in psychiatric care constituted the bulk of new learning. Four major content categories were identified through examination of the cards. These and the percentages of learning in each appear in Table 4. The category of Treatment Mode included such things as behavioral therapy, primal therapy, drug therapies, community resources and sensitivity groups; Group Functioning was concerned with patients and staff helping patients cope with self-defeating behavior. Sharing of knowledge, information, reactions and decisions were the essential components in the category of Team Functioning. Reactions to patient behavior and/or team decisions constituted the fourth category.

What happened with respect to the learning needs which had been identified? Did learning take place at the time or were the needed skills acquired later or not at all? All of the identified learning needs were taken care of in the situation, with the health team being the learning resource used most frequently. Table 5 presents the data with relation to six sources of learning.

TABLE 4

CONTENT OF NEW LEARNING NEEDS

	No	%
Team Functioning	32	64
Treatment Mode	13	26
Group Functioning	3	6
Own Reactions	2	4
Total	50	100

TABLE 5

SOURCE OF LEARNING

Source of Learning	No	%
Health Team	19	38
Nursing Team	15	30
Doctor	7	14
Individual Nurse	5	10
Patient Group	2	4
Self	2	4
Total	50	100

DISCUSSION OF RESULTS

My work in the day care centre was a re-vitalizing experience. Having patient care as the major purpose of my activities was satisfying. Also, although one is learning constantly, use of the Critical Event Record Cards gave a means of pinpointing learning experiences for analysis and provided a means for retention of the learning.

As we saw in Table 2, very little learning occurred in the categories of Assessing and Planning care. The reason might be that these skills are constantly used as a component of teaching. Although Giving and Evaluating care are also a part of teaching, the teacher does not use them directly with patients. Rather, the teacher's area of concentration is on helping the student gain needed knowledge and skills. The teacher's relationship to the patient is indirect; it is the nurse who must help the patient understand and change his self-defeating behavior.

In addition, with the new knowledge and skills that have been developed in giving patient care, it seems understandable that learning needs in the Giving and Evaluating category would be predominant. After many years of not being directly responsible for patient care I was out of touch with the recent developments in the actual giving of care. An example of this was the use of video tapes to help a patient assess his own improvement. One of the patients had had a back injury; although he was improving he denied this. By means of video-taping him walking, showing the tapes to him and discussing them with him, he was enabled to accept improvement and indeed to walk better. In another situation, I learned that schizophrenic patients could benefit by sensitivity groups. This is contrary to the literature, which states that these patients cannot tolerate closeness or confrontation. These and other incidents supported the idea

expressed by Smith that relevant teaching requires involvement with patient care(4). Some of the learning in the cognitive category consisted of basic knowledge which I had not previously acquired, or if acquired, had not had occasion to use. An example of this was in not providing a secondary gain for a patient with hysterical behavior. The patient was treated calmly and matter-of-factly and assured that she could help herself. She was able to do so.

There was no new learning in the Cognitive Affective category; possibly this can be attributed to previous comprehensive supervised practice in dealing with reactions. In one incident I had to deal with my reaction of finding it more difficult to accept illness in a male patient because of my personal values. By becoming aware of this I was able to control my personal feelings in my care of the patient. I was able to help him. I also had to deal with my reactions of non-acceptance that a patient could make no further progress toward better functioning. Once I accepted this I was able to support the patient at his level of functioning.

CONCLUSIONS, IMPLICATIONS FOR TEACHING

Use of the Critical Event Record Cards made this a very meaningful experience, most of which would have been lost without this means of recording. They continue to provide a source of recall and review. I anticipated that the first week would be mainly orientation and provide minimal learning. This did not happen. Learning started immediately and the greatest number of incidents were recorded during the first two weeks. I attribute this to having the framework to study the experience by use of the Critical Event Record Card. This could imply that in my teaching I must make every effort that students understand the frame of reference within which any learning experience is planned, in order that they have concrete categories for analyzing its meaning. In addition, the cards provide a ready reference source; any of the events can be used as illustrative material in teaching. Much of the material is information about new developments in patient care. Other incidents provide illustrations of how to deal with particular situations. The overall effect has been a revitalization of teaching.

I learned much about dealing with my own anxieties in relation to patients who are living in the community and are not under in-patient supervision. Much of the nursing is done on the telephone to help depressed patients come to the day care center. Team functioning is vitally important here, not only in providing consistency of care, but also in giving team members mutual support. Other anxieties developed due to being in a new setting and in a change of role from teacher to practitioner. Students' discomforts and anxieties during

clinical laboratory experience were seen in a new light. Since then, through sharing my own thoughts and anxieties with students, I am able to help them identify and cope with their own fears.

I have often questioned whether I could be a nurse and a teacher simultaneously. I now do not think this is an either-or proposition. Certainly, my nursing skills improved during this experience since I was responsible only for my nursing function in relation to patients. However, I have since learned that, for example, in groups students not only learn through observation of the teacher but gain confidence from observing the teacher making a contribution. Although there are many problems in clinical instruction it also has many challenges. Among these are the instructors' own learning needs. I hope that by sharing my experience some colleagues will be stimulated to consider their own further learning needs and derive benefit as I did.

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1. Dorothy W. Smith, *Perspectives on Clinical Teaching* (New York: Springer Publishing Co., 1968).
2. *Ibid.*
3. Phyllis E. Jones and Nora I. Parker, "The Identification of Learning Needs By Means of Critical Events," *Nursing Papers* 5 (Sept. 1973): 18-27.
4. Smith, *op. cit.*

The writer wishes to gratefully acknowledge the encouragement and support given by Dr. Nora I. Parker during the practice experience and the writing of the paper.

Proposed 1975 National Conference on Nursing Research

OCTOBER 27-29, 1975

The four Prairie university schools of nursing have applied for funding and are soliciting papers for a National Conference on Nursing Research to be held in Edmonton, on "The Development and Use of Indicators in Nursing Research." Active nurse researchers are invited to submit related papers to Margaret E. Steed, Program Coordinator, 3rd Floor, Clinical Sciences Building, University of Alberta, Edmonton, Alberta T6G 2G3.

THE FREEDOM TO LEARN

JENNIE WILTING
Associate Instructor
Grant MacEwan Community College

I believe that:

—I cannot teach another person directly, I can only facilitate his/her learning.

—A person learns most readily if he/she is interested in that which he/she is trying to learn.

—People differ in their ability to learn through any given teaching method.

—A person is capable of knowing best how he/she learns.

—A person is capable of carrying the responsibility of seeking out learning situations best suited to his/her needs.

—A person's evaluation of his/her own performance has a greater impact on his/her future behavior than the instructor's evaluation of that person's performance.

On this basis I planned and conducted a program in psychiatric nursing in which I attempted to allow the students as much freedom as possible to meet their own learning needs.

COLLEGE SETTING:

I carried out my program at Grant MacEwan Community College in Edmonton, Alberta. This college has a two year basic nursing program. Graduates of this program are eligible to write the qualifying examinations for Registered Nurse and to function in various health agencies as beginning practitioners in nursing. Courses in this program combine four major areas of study including physical and biological sciences, behavioral sciences, the humanities and nursing. Each nursing course consists of forty-five to sixty hours of classroom teaching with a total of one hundred and twenty to one hundred and fifty hours of clinical experience. Nursing experience is obtained in various hospitals and health agencies in the community.

The ages of the students range from eighteen to fifty-five years, with the average age of twenty-nine. Some of the students have had previous nursing experiences as orderlies and nursing aides. The students receive their psychiatric experience during the third trimester of their first year. Four instructors besides myself were responsible for instructing and supervising the students in psychiatric nursing. I had the approval and support of these instructors to plan and conduct this program for sixteen students.

CRITERIA FOR CREDIT:

To receive credit for the course the student was expected to spend approximately twenty hours a week or a total of 120 hours in a clinical situation or its equivalent and approximately seven hours a week or a total of 42 hours in class or its equivalent. The student was to perform satisfactorily in the clinical setting and to receive a grade of 60 per cent or higher in theory. The theory mark was derived from marks received in two written assignments, a midterm examination and a final examination. These were the same assignments and examinations given to the rest of the students.

SELECTION OF STUDENTS:

In selection of students for this group, I consulted with the instructors who had the students in the second trimester. I asked them to submit the names of students who they thought would be able to work independently, without needing a great deal of guidance. Five instructors submitted names, from which I selected sixteen students. There were several students whose names had been submitted but were not selected because of the limit set on the number of students I was to have in this group. The age of the students ranged from nineteen to forty-eight. Four students had hospital experience before enrolling at Grant MacEwan Community College.

ROLE OF INSTRUCTOR IN PREPARING THE COURSE:

My first task was to become aware of the clinical experience that I would be able to offer the students. Since there was a total of sixty-five students taking psychiatric nursing during this trimester, I was somewhat limited in this respect. I needed to work closely with the instructors who were teaching the other groups of students to prevent overloading any one clinical area.

Another task was to investigate the community agencies which could offer learning experiences. There were certain community agencies that could accommodate a very limited number of students for a short period of time. So that they could plan the experience, the agencies asked for the names of the students and the dates they could be expected before the beginning of the trimester. To assure that my students would have the opportunity to use these agencies, I arranged for each student to spend three or four days with one agency. This was done at random as I had no idea whether or not the student was interested in that particular agency. When the students were given their schedules, it was explained to them that they were expected to use these days as assigned. If they did not want this experience, it was the student's responsibility to find another student in the group

who was interested in going to that agency in her place. As it turned out, each student went to the agency as assigned.

Finally, there was the difficult task of explaining my program to people who would be more or less involved with it. Some people understood clearly what I was trying to achieve, while with others, I needed to settle for, "I don't really understand it, but you sound like you know what you are doing, so go ahead." However, as the program developed I received the co-operation of everyone involved.

CLINICAL EXPERIENCE:

I made myself available in the clinical areas at certain times. The student was free to come if he/she wished. Since the staff on the clinical area wanted to know how many students to expect, it was necessary for the student to let me know at least a day in advance if he/she planned to be there. Unless notified, I would assume that the student would not be on the clinical area.

The experience was a six week experience. The first week, I spent at a nursing home where the patients were not classified as psychiatric patients but many were suffering from such feelings as loneliness, worthlessness, anxiety and depression. The next three weeks, I spent in a general hospital on the medical and surgical units. The students worked with patients who displayed such symptoms as anxiety and depression, patients who were in the hospital for some physical condition but also had a psychiatric diagnosis such as schizophrenia, and patients who suffered from psychosomatic illnesses such as ulcerative colitis. The last two weeks, I spent in a large psychiatric hospital where patients received both short term and long term treatment for psychiatric disorders.

RESPONSIBILITY OF THE STUDENTS:

The students were expected to decide for themselves what types of experiences they wanted. As mentioned earlier, they were responsible for letting me know if they would be in the clinical area with me. The students were also responsible for keeping me informed as to how they were spending the day. If the student was going to be in a hospital area which was unsupervised by a clinical instructor, I cleared this with the staff member responsible for that area. It was important that this was understood and agreeable to the person in charge of that area. Both the staff member and the student knew where I would be and how to get in touch with me. If the student wished to spend time with a community agency other then the agencies we had contacted earlier, she made the arrangements herself. I gave the student a letter of introduction signed by me, which he/she could present to the

person in charge of the community agencies. Since it was possible that another student might be planning to contact the same agency, it was necessary that the student clear his/her plans with me before making the initial contacts. Not more than two students went to the same agency and none of them were turned down. The student was expected to give me an oral or written report regarding that experience. Many of these reports were given to the group as a whole.

The students were expected to formulate their own objectives and evaluate their own work. Whenever possible, they selected their own patients. Since the staff on the clinical areas wished to know a day in advance which patients the students would be working with, it was necessary for me to select the patients for the first day that the student would be in the area. The following days, they could make their own selection.

ROLE OF INSTRUCTOR DURING THE COURSE:

I found myself functioning very much as a resource person. I kept the students informed of my whereabouts at all times. They were free to call me at any time whether I was on a clinical area, in my office, or at home. The students came to me for help in evaluating their work and to plan their nursing care. They used me as a sounding board to express some of their feelings and frustrations. Frequently they came to share meaningful experiences with me and at other times, they merely needed to talk. I carried a notebook with me in which I jotted information about each student. The information included their objectives, where they were each day and my comments on their progress. I also had the students' home telephone numbers, so that I could contact them at home if necessary.

I needed to spend considerable time explaining my expectations of the students to the staff in the clinical areas. Since the students' behavior was often different from what the staff had learned to expect from students, I received such questions as: "Did I know that the student did such and such?" or "Was it okay that the student was doing thus and so?" For example, that the students rather than the instructor decided whether or not they would come to the clinical area was incomprehensible to some people. Occasionally, I needed to decide whether I would ask a student to change his/her behavior and conform more to "normal student behavior" or whether I would help the staff members deal with the anxiety that the student's behavior aroused. The behaviors most often questioned were the students' use of time, their approach to the patients, and their dress. I encouraged the staff to contact the students directly if they had any questions about their objectives or behavior. This was a new experience for

many of them since they were accustomed to going to the instructor and some were rather uncomfortable about going to the student. However, usually with a little support the staff were able to cope with their anxiety and the students were free to meet their objectives in their own way.

There was one situation in which I decided to remove the student from a particular clinical area. The student was meeting her objectives in her relationship with the patient and in my opinion, the patient was benefiting from the care. However, the anxiety of the staff rose to such a high level that it affected their relationship with the patient. After assessing the situation, I saw the possible danger of a situation being created in which the patient would suffer. How wise it was, I don't know, but I decided to remove the student. It was a difficult decision to make. When I told the student of my decision, I assured her that I did not view this as a negative reflection on her nursing care. She was very frustrated and angered by the incident and I empathized with her.

Working with this group of students was by no means an anxiety-free experience for me. At times, I found it difficult to allow the students to flounder around to find their way. Many times, I had to bite my tongue to keep from pointing out to the student that he/she was on the wrong track. To my amazement, the student usually managed to meet the objectives and both the student and patient benefited, reinforcing once again the idea that there is no one right way to care for patients. The students were able to carry even more responsibility for their own experience and learning than I had anticipated. I experienced mixed feelings about this. I felt good that they were able to carry responsibility as I had predicted but experienced some anxiety over their lack of dependence upon me.

It was difficult for me at times to allow the students to be responsible for their own behavior, especially when I anticipated that certain people would be upset by what the student planned to do. I experienced a desire to protect the students and at the same time I experienced some concern about the reflection their behavior would have on me. I was tempted, at times, to warn the students that their behavior would probably be upsetting to someone. When complaints about the students were brought to me, I found myself wanting to defend them rather than suggest that the person approach the student regarding their concerns. On the whole, the students appreciated being approached directly. If I thought that the behavior of the student would be harmful to either the patient or the student, I expressed my concerns and interfered if necessary. This was a responsibility which I believed I had toward both the students and the patients.

CLASSES:

The theory was taught concurrently with the clinical experience. I was responsible for the theory for my group of students, but I followed the same class schedule that was being used for the other group of students. Most of the classes I conducted myself but some were joint classes with the other groups. The classes were held on Monday of each week.

The students had four choices as far as classes were concerned. They could attend the classes which I conducted. They could attend the classes on the same topic that were being given to the other students. Since the classes were taped, they could listen to the tape and not come to class. Or they could study on their own without coming to class. Most students attended my classes, except when the class conflicted with another experience that they wanted to have.

For my classes, the students were expected to come prepared to discuss the topic. Usually I divided the topic and class in half. Half the students discussed one section while the other half discussed the other section. After the discussions, they reported back to the group as a whole which was followed by a brief total group discussion. To avoid feeling unneeded and because I thought that I had something to offer on basis of my years of experience, I took the last twenty minutes to share some of my thoughts and ideas on the subject with the students.

RESULT OF THE PROJECT:

The students' marks in theory ranged from 65 to 85 per cent with eight students attaining 75 per cent. The hours spent in the clinical area per student ranged from 120 to 180 hours with seven students spending between 120 and 130 hours in the clinical area. In the clinical area, I had from six to ten students with me every day. Four students stayed with me and did nothing different. Therefore, their experience was much the same as the students in the other groups except that they decided that this was what they were going to do rather than being told that this is what they were going to do. Furthermore, they set up their own objectives and evaluated them. Three students continued to work with patients in the nursing homes during the six weeks and at the same time worked with patients on the other areas. One student spent the first week with me and the remaining five weeks she worked on her own in other areas. Three students began projects which they will continue throughout the coming year.

At first the students' clinical objectives tended to be rather vague and broad, for example, observe symptoms of mental illness that the

patient demonstrates. Later, they were much more specific, such as: encourage Mrs. Jones to express her feelings of anxiety. Many objectives were aimed at working out feelings, either those of the student or the patient. Other objectives were aimed at skills which the individual student found difficult to master, for example, a talkative student set as her objective to talk less and listen more, while a quiet student tried to become more skillful at initiating conversation.

Many students were able to develop meaningful relationships with their patients and see positive effects of their nursing care. This was especially true with the patients who were on the medical and surgical units and in nursing homes.

The students experienced anxiety initially about the program and the responsibility they were expected to carry. They doubted their ability to handle it. Some students were angry about the arrangement. However, without exception, all students at the end of the experience indicated that they appreciated being in this group and found it a great learning experience.

Since each student planned her own schedule, they varied considerably. I will describe the schedules of two students to clarify how their time was spent. One student spent one week at a nursing home, one week in community nursing, and one week at a nursing convention. She researched the following areas:

1. The effect of deafness on the emotional health of children.
2. Sensitivity restimulation for older people.
3. Group therapy mainly involved with teaching and developing life skills.

To gain an understanding of these areas, she visited agencies, interviewed people and reviewed library material which dealt with these topics. During the time she spent at the agencies she either functioned as a member of the group or assisted the therapist. She submitted a written report on the topics and gave an oral report to the other students. She also commited herself to a thirty hours course in communications skills and four hours of volunteer work a week for the next six months at AID. AID is an agency which gives advice, instruction and direction to people in need via the telephone.

Another student spent one week on a medical ward and worked with a patient suffering from ulcerative colitis. She spent two weeks at a psychiatric hospital working with a disturbed adolescent. She spent two weeks at a convention and one week at an agency which deals with alcohol and drug addiction. She made a detailed study on the topic of "A Native Perspective on Alcoholism." She submitted a written report and reported orally to the other students.

STUDENTS' COMMENTS:

I would like to quote some of the comments made by students in their evaluation of the course.

—"This is the type of learning responsibility that I have always wanted but now that I have it I don't know what to do with it."

—"I like the way theory was presented. It wasn't! We found out on our own."

—"I liked the independence very much."

—"Instructor was available when I needed her but she was not breathing down my neck."

—"Felt a bit frustrated at first until I got organized as to what I was doing."

—"A good lesson in self discipline."

—"My most unique educational experience to date."

—"I had fun."

—"Fantastically 'together' idea."

—"At first, I was completely confused."

—"Free of the usual anxieties that come with 'scheduled' learning."

CONCLUSION:

I enjoyed teaching this group of students very much. I am more than satisfied with the outcome of this project. The students' response and performance exceeded my expectations. Some questions come to mind. Would the students have done as well if they had been picked at random? What effect did "having been picked" have on the students' motivation? How much did the enthusiasm of the instructor influence the students' performance? How would a group of students who at the present time are performing at a low level, function in this type of project?

I am looking forward to teaching another group of students in a similiar manner. Perhaps I will be able to answer some of these questions in the future.

REPONSE A "FREEDOM TO LEARN"

JULIENNE PROVOST
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J'ai lu "Freedom to Learn" (liberté pour apprendre) avec beaucoup d'attention, toutefois cet exposé a suscité de ma part nombre de questions brûlantes.

Mes premières interrogations se rapportent à la genèse et par conséquent au but de cette tentative pédagogique. En effet, je n'ai pas découvert les motifs qui ont animé madame Wilting à désirer une modification dans son enseignement. Quel problème spécifique avait-elle donc identifié et espéré résoudre à l'aide de "liberté pour apprendre"?

La sélection des seize étudiants m'intrigue également si je m'efforce de la relier au titre de l'article. Il me semble que ces étudiants a priori capables de fonctionner avec indépendance étaient "libres" pour apprendre. S'ils exerçaient déjà leur autonomie grâce soit à leur évolution ou peut-être à leur âge, par exemple, ceux de quarante-huit ans, pourquoi alors les exposer à plus de liberté? Par contre, des étudiants moins autonomes groupés de façon plus homogène quant à l'âge auraient-ils bénéficié d'une telle approche en les situant dans un contexte perçu comme facilitant l'auto-détermination.

D'autres nécessités de clarification tout aussi fondamentales se réfèrent aux croyances sur lesquelles repose cette "nouvelle" vision de l'enseignement. Par quel cheminement madame Wilting en est-elle venue à énoncer ces six croyances et à les préférer à d'autres orientations théoriques sur l'apprentissage? Ces croyances m'apparaissent d'inspiration rogérienne (1) même si je n'ai pas vu sa bibliographie. Si tel est le cas, lui a-t-il semblé difficile de prolonger au plan pédagogique une approche qui se voulait psychothérapeutique à l'origine? Les six croyances étaient-elles toutes nécessaires à sa tentative et reliées par un ordre logique? Pour n'illustrer qu'une alternative, aurait-il été pertinent de placer la dernière au lieu de la première appuyant ainsi le rôle du professeur sur les façons d'apprendre suggérées. L'auteur de l'article a-t-il défini à sa satisfaction les termes contenus dans chaque croyance afin d'en contrôler l'interprétation pour prévoir la méthodologie avec une certaine quantification si possible. Si l'on s'arrête à la première croyance formulée, que signifie l'expression "faciliter l'apprentissage"? Si l'on passe à la cinquième pour fins d'illustration également, l'expression "situations d'appren-

tissage les mieux adaptées à ses propres besoins" me paraît une source de difficulté. En nursing, les besoins d'apprentissage des étudiants se confondent quelquefois avec leurs désirs et ne sont pas indépendants des besoins de santé des clients, des contingences du milieu et de la profession en général. A-t-il été possible à l'auteur de vérifier si les situations choisies représentaient les mieux adaptées à cette notion complexe de besoins d'apprentissage? Que signifie "mieux adaptées"? Mieux que quoi? Et comment le savoir?

Une autre de mes difficultés et non la moindre, réside encore au niveau des croyances mais cette fois quant à leur concordance avec la méthodologie employée. Je n'ai pas toujours su concilier ces croyances avec le rôle du professeur dans l'intervention pédagogique ainsi que dans le choix, la planification et l'évaluation de l'expérience clinique tels que décrits dans l'article. En effet, j'ai constaté que, malgré une certaine latitude laissée aux étudiants, madame Wilting a apparemment, à maintes reprises, pris des décisions ("Students were responsible for"...) et spécifié des attentes ("Students were expected to . . .). Elles se rapportaient dans l'ensemble à une structure: moyens d'enseigner, nature, durée et qualité des expériences cliniques ainsi que comportements souhaités chez les étudiants. Ces derniers ont-ils eu l'occasion de participer dans la plupart des cas à ces décisions? Etait-ce souhaitable relativement aux croyances? De plus, dans le même ordre d'idées des croyances, laquelle exigeait du professeur une disponibilité imposant autant de limites à sa propre liberté du moins dans le temps?

Pour ce qui est des résultats que l'auteur signale au sujet de la formulation et l'évaluation d'objectifs, s'agissait-il d'objectifs d'ordre théorique ou clinique en rapport avec les besoins d'apprentissage? Etant donné que madame Wilting avait spécifié l'attente d'une performance satisfaisante, que signifiait cette "norme" au sujet des deux points en question? Si l'on se rapporte à la sixième croyance, aurait-il été utile de "faciliter" aux étudiants le développement d'un mode d'auto-évaluation sur ces mêmes points. Par exemple, procédaient-ils plus scientifiquement qu'avant la tentative et plus en rapport avec les effets de leurs interventions de soin. Quant à la troisième croyance, pouvait-il comparer les étudiants les uns aux autres, sur les mêmes aspects relatifs aux objectifs?

Pour évaluer leurs connaissances théoriques, madame Wilting a utilisé un examen standard appliqué à d'autres groupes. Les étudiants étaient-ils d'accord avec ce moyen extérieur? Pour ce qui est de la performance clinique, comment en est-elle venue à conclure que ses étudiants prenaient eux-mêmes leurs décisions et ceci mieux qu'un autre groupe? Lui était-il donc physiquement possible de suivre en

champ clinique un autre groupe en même temps que ses seize étudiants et de comparer les deux groupes?

Quant à son rôle de "facilitation", madame Wilting a-t-elle jugé utile de prévoir pour elle-même et peut-être à l'aide d'une autre personne, une façon de le vérifier à différentes périodes au cours du déroulement de sa tentative?

Dans l'ensemble, je me demande si l'application de cette approche s'est avérée aussi "facilitatrice" que les croyances exprimées le suggèrent. Quelle est l'influence de cette approche sur l'apprentissage des processus et du contenu aussi bien que sur leur agencement en nursing? Comment favorise-t-elle le passage de la subjectivité à l'objectivité chez l'étudiant? Comment parvient-il à contrôler ses fins et ses moyens relativement au client?

Madame Wilting a eu le mérite de désirer modifier l'enseignement du nursing et d'exprimer ses sentiments à cette occasion. Elle a choisi une approche qui comporte des difficultés de description et d'expérimentation en nursing; elle en a peut-être identifiées en cours de route. J'espère que mes points d'interrogation lui seront de quelque utilité pour examiner sa tentative. Même si je n'ai pas répondu directement à ses questions, je serais heureuse d'apprendre comment elle se propose de re-orienter et de poursuivre ses efforts.

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RESPONSE TO "THE FREEDOM TO LEARN"

SUSAN E. FRENCH
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The professional nurse must be a life-long learner who is capable of self-directed learning. Educational programmes in nursing have exerted, all too frequently, maximum control over the learning experiences and focused on "what" to learn rather than on "how" to learn. Predetermined content, objectives, method of learning and evaluation is believed necessary to minimize risks to patients, students and faculty and to prepare the student for her future role. Unfortunately highly structured and controlled learning experiences do not facilitate the development of self-directed, independent, self-evaluative learning skills. Creativity, motivation, problem-solving and responsibility may be reduced.

Considerable anxiety is aroused in the learner, the teacher and others when students are perceived as motivated, responsible, independent adults and given the opportunity to assume major responsibility for their learning. What happens when students are given the opportunity to identify their learning needs, to define goals, to make decisions regarding the use of learning resources and to evaluate their performance? Students respond favourably and learn, as Ms. Wilting demonstrates in her description of a self-directed learning experience for students. Fear of the unknown, decreased ability to predict responses, and changing role expectations are common sources of anxiety in both the learner and others. Recognition of the anxieties and their sources is a crucial task for the teacher in order to maintain anxiety at an optimal level for learning. The teacher requires trust in self and others as exemplified by Ms. Wilting.

Self-evaluation is an integral component of self-directed learning. Feedback from others is essential for a critical appraisal. In this situation did the students establish the criteria for evaluation and methods of evaluation. Did they elicit information from others? In the classroom experiences content and method of evaluation were predetermined, which was at variance with the clinical component. Evaluation by others and evaluation in relation to standards established by others is one means of obtaining feedback and it should be placed in that perspective. In order to achieve greater relatedness between learning experiences, could consideration be given to having student input regarding content and method of evaluation in all learning experiences?

Self-directed learning is not always applicable to all students and teachers at all stages of the learning process. Those who choose to participate in this method of learning are greatly rewarded, as evidenced in the comments by the students in this experiment. Freedom necessitates responsibility or it becomes license. Responsibility is a necessary attribute for all nurses. It behooves nurse educators to become more cognizant of this fact and to plan learning experiences accordingly. Ms. Wilting has demonstrated that self-directed learning can occur despite numerous constraints if the teacher is committed to this approach and is prepared to try.

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