NONTRADITIONAL CLINICAL SITES IN BACCALAUREATE NURSING EDUCATION

Miriam Joyce Stewart

Obtaining clinical sites for student experience is a major problem for nurse educators. A survey of 90 baccalaureate nursing schools revealed that 80 percent of clinical placements are concentrated in seven "traditional" settings: secondary-care agencies, homes, health departments, outpatient departments, tertiary-care settings, community health agencies, and schools (Graham & Gleit, 1981). Based on this finding, one could surmise that traditional placements incorporate in their philosophy, goals and objectives, a central focus on health care delivery and a clearly established nursing role.

Most faculty in schools of nursing have resisted change with regard to selection of clinical locales (Hawkins, 1980; White, Knollmueller & Yaksich, 1980). However, the goal of baccalaureate nursing education is to prepare a liberally educated individual to enter professional nursing practice in a variety of settings (Debeck, 1981; Kernen, 1979; Kramer, 1981; Thomas, 1979).

The School of Nursing of Dalhousie University, which adheres to this mainstream philosophy, is not unique in facing the inescapable fact that expanding enrolments ensure survival in an era of fiscal stringency. The evolutionary movement toward minimal baccalaureate preparation for the professional nurse will provide the impetus. However, the resultant increasing number of students requiring practical experience exceeds the capacity of conventional institutions to meet the demand. The accompanying inefficient trend of overloading certain agencies while avoiding others must be reversed.

Consequently, since 1977, our final year baccalaureate students have been allocated progressively to more "nontraditional" than traditional sites. The implementation strategies and impact of this five-year trial distribution of more than 200 students to 30 unique clinical settings are delineated.

Selecting Clinical Sites

The clinical curricular component of our school encompasses the "stress-adaptation" conceptual framework. The objectives of this fourth-year course emphasize the ability of the student to function as a client advocate, to facilitate the client's adaptive processes, to assume responsibility for personal growth and development, and to be accountable for individual interventions. The development of critical analytical thinking is the ultimate goal of this course.

Miriam Joyce Stewart, R.N., M.N., is associate professor, School of Nursing, Dalhousie University, Halifax, NS.

This paper was originally accepted for publication in January 1983.

Opportunities have to be provided for these senior students to adapt to communities and community groups, problem-solving, communication, teaching, change-process and leadership skills previously applied to individual and family-centred care. Therefore, traditional settings were explored. However, not all students could be readily accommodated by community-health agencies for an extended "reality-based" experience. Therefore, the search for clinical placements was initially expanded to include community settings with an obvious health component, such as physicians' offices; preventive medicine, prenatal, child guidance and drug clinics; family-medicine centres, and the Cancer Society. Later, nontraditional agencies with no readily apparent health focus, including social service departments, school guidance departments, and youth drop-in, day care and neighbourhood centres, were approached.

An alternative approach to the selection of nontraditional sites could have been geographic dispersal of the students. However, peer support and faculty guidance would have been less accessible. Furthermore, transportation, living accommodations, and timetable problems impeded consideration to this option.

The agencies selected met implicit criteria which evolved directly from the objectives of this clinical course. Specifically, they provided the opportunity for students to function independently and interdependently while focusing on the community as client. The assumption that traditional agencies tend to emphasize therapeutic and to a lesser extent preventive interventions, to the virtual exclusion of health-promotion activities, was not *initially* the primary determinant in site selection.

Students are placed in one of these settings for the equivalent of eight hours a week during their senior year. To develop initiative and responsibility for personal learning as well as to initiate the process of cutting the umbilical cord, instructors are rarely present while students are in the agency. Therefore, students learn to consult appropriately the agency staff (both nurses and nonnurses) as resource people. They develop individual projects that relate not only to the clinical course objectives, but also to the agency's goals and regulations. As these placements vary widely, so do the functions, roles and activities of the students.

Illustrations of the scope and diversity of these student experiences follow.

Neighbourhood Centre

Most staff members employed by this centre, located in the vicinity of a low-income housing development, are paraprofessional social workers and child-care workers. The flexible, loosely structured atmosphere meets the socialization and support needs of residents.

Following initial culture shock (Toffler, 1970) students became involved in incorporating health-related topics into a women's weekly discussion group; teaching preschoolers about hospitalization, safety and immunization; and leading after-school, latch key group programmes on babysitting and first aid. They concluded their experience by designing a comprehensive inservice programme on human sexuality. This addressed an acknowledged need of staff for preparation in relevant counselling and education techniques.

Youth Drop-in Centre

This particular centre serves transient and resident teenagers in a downtown area. Its location above a popular health-food store and the staff's casual dress create a homelike atmosphere for the adolescent target group.

Here, two nursing students developed group health education posters and programmes focusing on smoking, drugs, nutrition and family planning. These programmes were then implemented not only in the centre itself, but also in neighbourhood schools, libraries, and a mobile Youth Caravan.

Social Service Department

The stated objectives of this metropolitan agency revolve around the provision of family support, child protection, placement and counselling services, in addition to short-term financial assistance.

Through contacts with residents and professionals, students assessed the unbalanced nutritional intake as a priority problem. Working in direct collaboration with a social worker, a nutritionist, and a representative of the Senior Citizens' Council, they produced television programs, pamphlets, informational sessions and a cookbook for the single person on a restricted diet.

Multi-service Centre

A centre combining social, recreational and health-related services under one roof and linking others in the surrounding communities in a liaison system was opened recently, in a newly developed suburban community where transience and parenting and marital problems prevail. The home-nursing and public-health agencies, representing the largest proportion of community-health nurses in the area, are not located in the centre itself. Cooperation and collaboration are the key

operating principles of the centre. Multiple disciplines are co-ordinated by the executive director — a social worker.

Prior to the establishment of the centre, nursing students joined with social work students in developing an information registry of community and agency services in response to an expressed need of residents. Following the opening, the nursing students assessed community residents' reaction to, and awareness of, the services offered and produced innovative informative shopping mall displays. Furthermore, they made valuable contributions to board and committee meetings, ranging from interpretation of consumer perceived needs to shared evaluation of the group's process and progress.

YMCA

The medical clinic component of this recreational centre caters mainly to the needs of urban, middle-class residents. Ongoing programmes include fitness testing, prenatal and postnatal classes, cardiovascular risk assessment and recovery programmes, and stress testing.

Following an initial assessment of the agency and its clientele, one student conducted exercise classes and pulmonary function tests. This decision was based on a personally assessed need to learn approaches to lifestyle assessment and health promotion. Another, developing her teaching and group-process skills, helped coordinate a group for obese adolescent girls, developed a comprehensive report on the group's progress and formulated recommendations for the future. Students began to develop and demonstrate a role for the nurse in a structured setting in which only the physician, physical educator and nutritionist had clearly established functions. Hence, exciting new channels for nursing input had been discovered.

Student Insights and Accomplishments in Nontraditional Settings

Consider the experience of nursing students in the neighbourhood centre described. Initially, they had difficulty bridging the gap between their own middle-class, health-oriented values and those opposing views of the staff and clients. Accustomed to taking orders from instructors, head nurses and physicians and to wearing immaculate white uniforms, the students did not have specifically assigned duties and had to wear jeans to establish credibility.

Initially, students worked with the women's family-life group: they lectured on childhood diseases, nutrition and exercise — problems they assumed that this primarily middle-aged, overweight, single-parent group would be concerned about. However, they learned quickly that these women saw the centre as an escape from daily drudgery, a place to meet friends, have coffee and share concerns.

Students recognized the value of flexible, informal discussion sessions, incorporating films and role playing, and spontaneously addressing issues raised by members.

Further, students observed that attendance improved when group members themselves identified topics for discussion, and when they used outreach tactics such as advertising in a neighbourhood newsletter. Thus, problems as varied as living accommodations, religion, schooling, parenting, rape and family violence became the new diverse health-related foci of stimulating sessions.

The concept of individual rights was applied as students began to connect theories of poverty taught in the classroom to the feelings of powerlessness these women were experiencing. These graduating nurses came primarily from middle-class backgrounds that emphasized ambition and hard work as the sure road to success. Only practical experience showed them that this group, which they had labelled "indifferent" and "apathetic" by *their* standards, was responding defencelessly to barriers imposed by living conditions in this neighbourhood. This discovery was reinforced by home visits where the students were confronted with "cement playgrounds, littered garbage and homes in disrepair."

Students established contact with appropriate resource people, including clergy, housing authority personnel, family planning physicians and nurses, and crisis centre workers, as they acknowledged the futility of working in isolation when dealing with complex health issues. Thus, residents were introduced to potential health-related services available to them.

Advantages and Disadvantages of Use of Nontraditional Settings

The benefits accrued from using these diverse nontraditional sites for community-health clinical experience were numerous. Students

1. enlarged their perspective of the scope of health-care services and community resources and identified obstacles and gaps in the health-care-delivery system;

2. participated actively in interdisciplinary teams and learned the roles of many health-related professionals and paraprofessionals;

3. confronted their personal values and stereotyped attitudes;

4. through a process of contracting, involved consumers in the planning and evaluation of care, thus developing client advocacy skills;

5. practised group-leadership skills and merged individualistic approaches basic to nursing with aggregate strategies basic to community health;

6. provided valuable contributions to the community and agency as they negotiated and developed nursing functions and activities;

7. gained self-confidence and acted autonomously and responsibly; and

8. most significantly, reinforced and demonstrated their inherent belief that health is much more than a physical state — that its social, spiritual and psychological components must be intermingled in health-promotion interventions.

To summarize, the students learned how to facilitate the clients' efforts (whether individual, family or community) to assume independence and responsibility for health status. Maddison (1980) notes that the complexity of such professional-consumer relationships has been a neglected dimension of professional education. In these settings, students acquired and improved skills related to teamwork, communication, analytical problem-solving, self-evaluation and accountability. Epidemiological principles, systems theory, stress-adaptation concepts and the nursing process itself assumed new meaning as students applied them to communities and community groups. Finally, they gained proficiency in the application of change strategies. In short, the knowledge acquired and the skills mastered in a nontraditional milieu related directly to the objectives of this clinical course.

The vast majority of feedback from agency preceptors at the end of the academic session was favourable. However, it must be acknowledged that time and energy were expended and frustration and resistance encountered as nursing roles were integrated into nontraditional agencies. Some of the resistance that occurred appeared to be related to the traditional view of "legitimate" nursing functions held by some students and by staff in structured settings. Therapeutic "laying on of hands" and technical skills persisted as perceived practice needs. Nagging doubts, reflected in such phrases as "waste of time doing nonnursing activities" and "never be employed in such settings," surfaced in the initial phases of the experience. Further, the "go-to-it" attitude conveyed by staff in the more unstructured sites disconcerted students who craved explicit direction and who interpreted this as disinterest.

Agency staff in some volunteer- and other-discipline-run departments had to witness demonstration of a nursing role over a period of years in order to provide useful evaluation of student performance and to facilitate the entry process of new students. Initially, guidance counsellors, social workers, and medical practitioners did not comprehend or acknowledge the nursing skills of counselling and client education. As staff in these agencies changed, an intense orientation

session was a requisite element. Further, review for experienced preceptors was frequently necessary. Even public-health nurses visiting the schools in which students were working with guidance personnel, questioned their respective roles. Therefore, students developed collegial relationships with nurses in more traditional roles.

We found that placing students in pairs, holding weekly seminars to provide peer and faculty support, and encouraging ongoing communication between preceptors, faculty and students did much to overcome these obstacles. In this context, incentive for pursuing new avenues of role development, through formal inservice or continuing education programmes, appeared to be lacking in some agencies.

Discussion

Other nurse educators identify the use of voluntary health care agencies and associations, senior citizen and nursing homes, health departments, family practice, free clinics, ambulatory care units, public schools, planned parenthood groups, alcohol rehabilitation programmes, day care, expectant parent classes, and a campus health information centre as clinical learning laboratories in the community (Adams, 1980; Clark, 1977; Heggerty & Kidzma, 1980; Lawrence & Lawrence, 1980; Mezey & Chiamulera, 1980; Ruffing, 1979; Schenk, 1976; Sorgen, 1979). The majority of these could be considered traditional sites according to Graham and Gleit's (1981) typology, with one possible exception. In contrast to these authors' description of nurses employed full time within a particular educational institution, the school nursing functions tend to be subsumed within the official community health agency workload in this country.

Cox (1982) predicts that client needs will become increasingly diversified such that the *context* in which nurses will practise will inevitably change. She refers to the current shift from cure to care, a trend pinpointed by Lalonde (1974). Six years later, Hall (1980) supported the Canadian Nurses Association's (1980) contention that spending be directed toward primary prevention, health promotion and noninstitutionalized community-based points of entry. Yet, this adaptation of health service delivery demands different and creative orientations of manpower (Baumgart, 1982; Pender, 1982). Specific strategies to develop relevant knowledge and skills and to promote role transition (Kramer, 1974) are required. Hence, university schools of nursing must prepare for these altered roles and practice sites by reflecting these changes in the theoretical and clinical components of their curricula (Greaves, 1982; Smith, 1982).

Clinical agencies should be selected on the basis of characteristics which are directly related to these trends and objectives for clinical experience (White et al., 1980). Criteria might focus on opportunities for

continuity of relationships with staff and clients or for application of aggregate-level skills (Pridham & Hurie, 1980; William, 1977). Nevertheless, tradition, location, availability, access, numbers, competition, choice, attitudes and time do influence the selection process (Hawkins, 1980; Robischon, 1978; White et al., 1980). For example, some nursing faculty may cling to the belief that principles of public health nursing can only be learned in public health agencies, curriculum demands of other courses may constrict potential travelling time, and multiple learners representing nursing and other disciplines may be competing for the same agency.

In this experience, a gradual transition began with a cautious selection of agencies, whose aims and services were closely linked to the more traditional variety. Once it was established that these were indeed congruent with the goals of the baccalaureate programme, the search for clinical placements evolved to include less familiar sites. Freedom of choice, transfer of learning, development of problem-solving skills, role modelling, flexible teaching environment, and change strategies contributed to the positive outcomes of this venture.

Freedom of choice was a key factor in the success of this clinical programme. Although they did not choose their agency, students had opportunities to be creative and adaptive in functioning in a nursing role and were offered alternative yet comparable learning experiences. As White et al., (1980) and Robischon (1978) indicate, less traditional settings promote flexibility and variety, provide services to groups of people and are open to supporting expanded nursing functions. However, Roper (1976) cautions educators to remember that labels of settings do not necessarily reflect the type of experience to which students will be exposed and that clinical areas often provide unexpected nursing experience.

A second major premise underlying the selection of a multiplicity of varied settings in this experience was an inherent belief in the ability of senior level students to *transfer learning*. To promote transfer of learning and to stimulate the retrieval of previously learned intellectual skills, a variety of environmental contexts and cues must be provided. A range of probing questions, varied examples, and novel situations facilitate transfer to other experiences (Gagne, 1974; Huckabay, 1980). These strategies were applied to this experience with nontraditional sites. However, general principles must be comprehended before transfer can be expected, as Smith (1982) contends, interrelating curriculum design, process and content facilitates student learning. Thus, the accompanying theory course and preceding theoretical-clinical courses were applied and integrated.

Gagne (1974) relates transfer ability and creativity to *problem-solving* skills. Therefore, faculty teaching this clinical course invoked recall of relevant concepts and principles, assessed learner's entering behaviour, identified expected terminal performance, required varied demonstrations, and provided verbal directions without giving the solution. Analysis and synthesis were expected from these senior level students. Thus, the ability to relate ideas, to identify hierarchy of ideas, to organize content, to combine parts, to derive patterns and to make generalizations by identifying commonalities and differences were learning goals (Huckabay, 1980). Ketefian (1981) found that critical thinking was positively associated with moral reasoning and abililty to function optimally and independently in complex milieu. Therefore, students were asked to give and defend their opinions, they were challenged to make their own decisions and to articulate their judgement, and they were held responsible for identifying their learning needs, performance problems and roles.

The professional role is learned through interaction with people inside and outside the school (DeCecco, 1974). Changes over time, following employment, in role concepts and values have been attributed to *role models* encountered by new nursing graduates (Shuval & Adler, 1980). Social behaviour patterns are learned and attitudes established and modified through the combined influence of models and reinforcement (Bandura, 1977; Huckabay, 1980; Kramer, 1974). Three identified effects of this phenomenon are modelling, inhibiting or disinhibiting and eliciting (Maddison, 1980). In the experience with this fourth-year clinical course, a variety of models in a range of clinical settings were used and nursing staff role models were frequently unavailable. However, students developed an ability to discriminate values adhered to by staff and to be selective in absorbing values. Students dissatisfaction with teaching and supervision by agency staff was a continuing phenomenon. Therefore, it was essential that both faculty and preceptors recognize and acknowledge their own fallibility as models. The fact that nursing faculty were not present "on site" in this experience made innovative approaches to role modelling essential.

Huckabay (1980) contends that the teacher's primary function is to provide *environments* that promote the development of the individual learner and to produce given educational objectives. Decisions must be made about the educational value of the environment. Therefore, throughout this experience, faculty facilitated, counselled, evaluated, consulted and coordinated. They identified potential agencies, conducted preliminary negotiation and planning sessions with staff, guided

agency representatives in their supervisory role and incorporated preceptor input into student evaluations. Furthermore, they supported and guided students through extensive feedback in written assignments, individual interviews and weekly group problem-solving sessions. As Bandura (1977) recommends, nondirective, collegial relationships between faculty and students were the norm. Nevertheless, as faculty change there is an inherent risk that commitment to the nontraditional clinical locale may falter.

Smith (1982) proposes that a number of different loci can impose stressors on staff and students. Consequently, tolerance, supportiveness, flexibility, openness to new knowledge, motivational climate, educational preparation, and conceptual understanding (Greaves, 1982) were all prerequisite *change strategies*. This innovation required new skills, attitudes and value orientations in students and preceptors alike. In some cases, trust was difficult to establish and role conflicts occurred. Individual attitudes required as much attention as structural changes, as "normative re-educative" theory (Bennis, Benne, & Chin, 1969) dictates. Therefore, faculty acknowledge that agency personnel require formal recognition; for example, identification of preceptors in the university calendar, joint appointments and honoraria. Some faculty members have provided direct services to agencies in the form of client care and continuing education programmes. Finally, faculty members organized a "Community Experience Reporting Day" at the conclusion of the course, which emphasized the synthesis of students learning regarding role development and group level interventions. This gave students an opportunity to share information about approaches used and projects completed in these multiple settings and to express appreciation to preceptors.

Conclusion

It is somewhat ironic that a quest for community placements based primarily on necessity created a desirable alternative thrust in clinical experiences. These non health-focused settings in fact reinforced a healthy perspective that traditional agencies used in the past had not stressed. Students developed an expanded repertoire of behaviours and were afforded the opportunity to improvise. The success of the programme points to a need to continue and expand this approach. Potentially relevant placements currently being investigated include apartment dwellings predominantly rented by single parents and the elderly, boys' and girls' clubs, and informal neighbourhood aggregates or networks.

This experience demonstrated that collaboration with nontraditional agencies can be rewarding. Students encountered new dimensions of nursing and health services in these community-based agen-

cies. They learned to adapt theoretical principles and analytical approaches to holistic, client-centred care, regardless of the setting. Such flexibility is mandatory if nursing is to meet changing societal demands.

Appropriate learning opportunities abound when accompanied by comprehensive planning and careful guidance. The transition from role identification to programme commitment is a requisite element for students, preceptors and faculty alike. These developing learning laboratories should complement, not replace, the more conventional varieties. Further research is required to evaluate the long-term effects, if any, of student placement in nontraditional versus traditional sites on the retention of community health concepts and graduates' position selection and perseverance in the profession.

REFERENCES

Adams, D. E. (1980). Agency staff facilitate student learning. *Nursing Outlook, 28,* 382-385.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall.

Baumgart, A. J. (1982). Nursing for a new century — a future framework. *Journal of Advanced Nursing, 7,* 19-23.

Bennis, W. G., Benne, K. D., & Chin, R. (1969). *The planning of change,* 2nd. ed. New York: Holt, Rinehardt & Winston.

Canadian Nurses Association (1980). Putting health into health care. Submission to Health Services Review '79, Ottawa, C.N.A.

Clark, C. C. (1977). Learning to negotiate the system. *Nursing Outlook, 25,* 39-42.

Cox, C. (1982). Frontiers of nursing in the 21st century: Lessons from the past and present for future directions in nursing education. *International Journal of Nursing Studies, 19*(1), 1-9.

Debeck, V. (1981). The relationship between senior nursing students' ability to formulate nursing diagnoses and the curriculum model. *Advances in Nursing Science,* 3(3), 51-56.

DeCecco, J. P. (1974). *The psychology of learning and instruction: Educational psychology.* Englewood Cliff, NJ: Prentice Hall.

Gagne, R. M. (1974). *Essentials of learning for instruction.* Hinsdale, IL: Dryden Press.

Graham, B. A., & Gleit, C. J. (1981). Clinical sites used in baccalaureate programs. *Nursing Outlook, 29,* 291-294.

Greaves, F. (1982). Innovation, change, decision-making and the key variables in curriculum implementation. *International Journal of Nursing Studies,* 19(1), 11-19.

Hall, E. M. (1980). Canada's national-provincial health program for the 1980's. Commitment for renewal. Ottawa: Health and Welfare Canada.

Hawkins, J. W. (1980). Selection of clinical agencies for baccalaureate nursing education. *Journal of Nursing Education,* 19(8), 7-17.

Heggerty, L., & Kidzma, E. C. (1980). Expectant parents' classes. An alternative environment for learning health maintenance. *Journal of Nursing Education*, 19(1), 13-19.

Huckabay, L. M. D. (1980). *Conditions of learning and instruction in nursing.* St. Louis: Mosby.

Kernen, H. J. (1979). Tailoring nursing education programs to meet the nature of community needs. *Nursing Papers, 11*(1), 6-18.

Ketefian, S. (1981). Critical thinking, educational preparation and development of moral judgment among selected groups of practicing nurses. *Nursing Research, 30,* 98-103.

Kramer, M. (1981). Philosophical foundations of baccalaureate nursing education. *Nursing Outlook, 29,* 224-228.

Kramer, M. (1974). *Reality shock: Why nurses leave nursing.* St. Louis: Mosby.

Lalonde, M. (1974). *A new perspective on the health of Canadians.* Ottawa: Information Canada.

Lawrence, R. M., & Lawrence, S. A. (1980). Student experience in voluntary health care agencies. *Nursing Outlook, 28,* 315-317.

Maddison, D. (1980). Professionalism and community responsibility. *Social Science and Medicine, 14*A, 91-96.

Mezey, M., & Chiamulera, D. N. (1980). Implementation of a campus nursing and health information center in the baccalaureate curriculum. Part I: Overview of the center. *Journal of Nursing Education,* 19(5), 7-15.

Pender, N. J. (1982). *Health promotion in nursing practice.* New York: Appleton-Century-Crofts.

Pridham, K. H., & Hurie, H. R. (1980). A day care health program: Linking health services and primary care nursing education. *International Journal of Nursing Studies, 17*(1), 55-62.

Robischon, P. (1978). Community health and expanded assessment skills. In *Utilization of the clinical laboratory in baccalaureate nursing programs.* New York: National League of Nursing Publication, 15-1726, pp. 1-23.

Roper, N. (1976). *Clinical experience in nurse education.* Edinburgh: Churchill Livingstone.

Ruffing, M. A. (1979). Community health nursing in an urban day care center. *Journal of Nursing Education, 18*(8), 21-26.

Schenk, K. (1976). Teaching distributive nursing. *Nursing Outlook, 24,* 574-577.

Shuval, J. T., & Adler, I. (1980). The role of models in professional socialization. *Social Science and Medicine, 14*A, 5-14.

Smith, L. (1982). Models of nursing as the basis for curriculum development: Some rationales and implications. *Journal of Advanced Nursing, 7,* 117-127.

Sorgen, L. M. (1979). Student learning following an educational experience at an alcohol rehabilitation centre in Saskatoon, Saskatchewan, Canada. *International Journal of Nursing Studies, 16,* 41-50.

Thomas, M. C. (1979). Study difficulties in undergraduate nursing students — a British perspective. *International Journal of Nursing Studies, 16,* 299-305.

Toffler, A. (1970). *Future shock.* New York: Random House.

White, C., Knollmueller, R., & Yaksich, S. (1980). Preparation for community health nursing: Issues and problems. *Nursing Outlook, 28,* 617-623.

Williams, C. A. (1977). Community health nursing — what is it? *Nursing Outlook, 25,* 250-254.

RÉSUMÉ

Enseignement universitaire des sciences infirmières en milieux cliniques inhabituels

Le nombre croissant des inscriptions en sciences infirmières assure la relève à une époque de restrictions budgétaires. L'évolution vers la reconnaissance d'un baccalauréat comme préparation minimale à la profession infirmière en sera le moteur. Toutefois, le nombre accru d'étudiants qui devront acquérir une expérience pratique dépassera les capacités des établissements traditionnels. C'est pourquoi, depuis 1977, nous avons progressivement dirigé nos étudiants de dernière année du baccalauréat davantage vers des milieux non traditionnels que vers les lieux de stage habituels.

La transition graduelle a commencé par le choix prudent d'organismes dont les objectifs et les services étaient étroitement liés à ceux des milieux traditionnels. Quand il fut établi que ces milieux se conformaient aux objectifs du programme du baccalauréat, nous avons poussé nos recherches pour étendre les stages cliniques à des milieux moins familiers. L'exercice de la liberté de choix, du transfert de l'apprentissage, de la résolution des problèmes, du modèle de rôle, en milieux souples d'enseignement, ainsi que des stratégies de changement sont autant de facteurs qui ont contribué aux résultats positifs de cet essai.

Les étudiants ont pris connaissance de nouvelles dimensions des sciences infirmières et des services de santé au cours de leur stage au sein d'organismes axés sur la communauté; ils ont appris à adapter les principes théoriques et les démarches analytiques à des soins globaux axés sur le client, quel que soit son environnement. Il est évident qu'une telle souplesse est essentielle si l'on veut que la profession infirmière soit en mesure de faire face aux exigences d'une société en pleine évolution.

Ces nouveaux laboratoires d'apprentissage devront compléter et non remplacer les milieux conventionnels de stages. Il faudra procéder à des recherches plus poussées pour évaluer les effets à long terme de ces stages en milieux non traditionnels et pour les comparer aux stages en milieux conventionnels; la constance des diplômés au sein de la profession et le type de postes occupés dans leur carrière en seront les critères d'évaluation.