Today, a large percentage of nurse anesthetists function not only as clinical practitioners but also as instructors. As instructors, they have had to learn how to write course outlines and behavioral objectives, create valid test questions, design curricula, and perform a myriad of tasks for which they may not have been formally prepared. In this article, the author stresses the need for instructors to learn how to teach effectively in a clinical setting.

In the health care professions, students have historically been taught in didactic-practicum settings. After being taught in formal lecture sessions, the student then was assigned to "the clinical area," that is, a hospital-based site where the student had the opportunity to integrate the material presented in the classroom with practical "hands-on" experience known as "training." Knowledgeable practitioners in each particular discipline acted as clinical instructors.

Operating under the framework of the "see one, do one, teach one" philosophy, the instructor demonstrated techniques of practice to the student, who was then expected to develop technical skills, read appropriate materials and was encouraged to ask questions. Learning was, mainly, via the "discovery" method.

Instructors evaluated students' clinical performance by comparing their skills with those of others at similar levels, and/or using their own (the instructor's) level of performance as the standard for evaluation. It is interesting to note that one definition of "train" in the Merriam-Webster Dictionary is "to cause to grow as desired." If the student did not fulfill the performance standard preset by the preferences of the clinical instructor, the student's clinical grade and progress were, often, jeopardized.

Today's changing philosophy

Today, clinical instructors face a growing change of attitude in health care education. Where once health care professionals thought of a clinical experience as a "training" environment, they have come to realize that not only psychomotor skills are learned, but cognitive and affective objectives must be achieved as well. To achieve these objectives, educational programs must have clinical instructors who are not only competent practitioners, but true "teachers."

Faculty members from medical, dental and allied health professions' schools are often faced with a lack of formal preparation for their duties as "teachers." This lack of preparation is neither the result of neglect nor lack of interest on the part of the health care professional. It is, instead, principally a lack of opportunity in the professional education; for, to be properly educated in a
profession does not automatically include preparation to instruct others in the duties of the profession.

Practitioners interested in the educational process should be encouraged and motivated to pursue further education in the areas of curriculum development, instruction, and evaluation. Professionals in the health care field must give up their claims to omniscience and recognize their inadequacies in the areas of developing, implementing and evaluating educational strategies. (Ausubel.)

**The role of the clinical instructor**

Clinical instructors have the greatest influence on the development of competencies within the student. They must recognize their vital position and learn the process of communication, and its role in instruction. Gagne stresses “total communication” that sequentially directs and develops the learner.

One begins by controlling the attention of the learner and, through a series of processes, promotes the transfer of learning from the immediate instructional setting to new tasks of learning outside or inside the setting. Gagne stresses that education is, itself, a process of communication. He feels that communication is an inevitable part of instruction, but, by no means, the whole.

Thorndike (cf. Jonich, 1962, p. 74) pointed out that, “Telling is not teaching.” Some clinical instructors feel that their job is being performed adequately by merely communicating directions and then watching the student perform (or not perform) according to the directions. Proficient clinical instructors realize that not all individuals learn by the see one, do one, teach one method.

Communication is not merely the giving of directions, but it is a multi-faceted affair that ranges from getting the student interested in the practicum to helping him/her achieve the higher level goals of application, analysis, synthesis, evaluation and problem solving—functions that are essential in the health care provider.

Learning experiences should be pre-planned for the student, with questions and assignments building upon each other. Learning in the health care professional should be cumulative and distinctive (Gagne). Behavioristic approaches to learning will not provide the community of interest with knowledgeable practitioners relating theory to practice, but technicians capable of performing at simple levels of achievement, such as rote learning, and verbal chaining.

Ausubel believes that learning occurs in a cognitive structure of two intersecting dimensions, that is, rote-reception learning and meaningful-discovery learning. Academic programs in the health care area provide adequate opportunity for rote-reception learning, but it is the clinical instructor who aids in meaningful-discovery, that is, the learning which consolidates basic parts to form a complex whole. The students, with clinical instructor guidance, should learn how to integrate the parts and adapt them to specific situations and patient needs.

Also important to the clinical instructor should be the perception, processing, and storing of information by the student. Travers' theory explains how people learn along with what are the maximum capacities of the human mind for information processing. By understanding this theory, the instructor can present an appropriate amount of new material and may lessen the frustration felt by the student. Indeed, it is frustration and its byproduct, anxiety, that often block student learning and progress.

High levels of anxiety can produce negative attitudes in the students both toward themselves and the program. Attitudes most definitely affect learning (Bruner). The incidence of withdrawal, probation and dismissal may well be lessened by educators who understand learning processes.

**Curriculum development**

Ausubel notes that most science programs have been designed and implemented by scientists, rather than educators. Learning theory specialists have only “peripherally” participated in curriculum development, because these education-specialists lack subject-matter competence. Thus, the responsibility has been placed upon clinical practitioners to develop curricula for health care education programs because they have the science knowledge-base necessary. Many practitioners have had to self-learn pedagogical skills in order to provide students with the structured educational experiences required in today’s programs.

Faculty, however, cannot be solely responsible for gaining competencies in educational methodology and practicing these techniques in their particular clinical environment; administrators and instructors within the educational system should make every effort to support faculty development as well. Inservice programs should be instituted within health care facilities to “teach teachers how to teach.” Through the use of well-designed faculty inservice programs that encompass educational theories, development of objectives, counseling of students, techniques of objec-
tive evaluation, and myriads of other topics germane to clinical supervision, the directors of programs can develop a unity of effort among faculty members and a well-coordinated, enriched program.

The best designed curriculum is only an impressive sight "on paper" if the faculty is not capable of implementing it. Sr. Mary Arthur Schramm, CRNA, director of Mt. Marty College School of Anesthesia in South Dakota, stated at the AANA Assembly of School Faculty in March of 1978, that, "the Director is responsible for the quality of the faculty; the faculty is responsible for the quality of the students."

If directors of health care educational programs strive to create an environment where clinical instructors can share ideas and develop clinical supervision skills, they also will have created an environment which maximizes student learning, minimizes student anxiety and promotes positive attitudes in future health care providers. Clinical instructors should work jointly to accomplish this goal.

Conclusion

Webster's Unabridged New Twentieth Century Dictionary states the first definition of "supervisor" is "a spectator." In parenthesis after this definition is an indication that the meaning is obsolete. Clinical instructors must continually re-evaluate their responsibilities and roles. To serve, merely, as a spectator places the clinical instructor in the realm of the obsolete.

The theories mentioned in this article and the strategies of diagnostic and clinical supervision are vital tools for the clinical instructor. Faculty appointments, ideally, should be based upon the competent use of these strategies and concepts. The theories and teaching-learning process should become as familiar to the clinical instructor as are the particular physical tools of the profession, for such theories are just as important in the practice of the profession.

REFERENCES

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