WHAT. WHAT. WHAT.
CLINICAL JUDGMENT IN TANZANIAN NURSE EDUCATION

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ABSTRACT

This study explored two facets of clinical judgment in Tanzanian nurse education. The first was to examine the perceptions of Tanzanian nurses regarding the use of clinical judgment during their nursing education. The second purpose was to scrutinize perceived benefits and obstacles of establishing approaches to the development of clinical judgment in Tanzanian nurses. The sample consisted of ten Tanzanian nurses whose experience ranged from two to eighteen years. A qualitative research design of phenomenology was used in designing a semi-structured interview guide to conduct the interviews. Four major categories of Patient First, Thinking More, Attending the Patient, and What. What. What., were gleaned from the data. The interviewees were forthcoming in relating positive educational experiences as well as their perceptions of obstacles to the development of clinical judgment. The interviewees were able to offer recommendations for augmenting that portion of nursing schools’ curricula that deal with the development of clinical judgment. The researcher anticipated that the interviewees would provide answers that would be specific to help Tanzanian nursing students and nurses develop clinical judgment. However, the researcher found that the participants’ suggestions for the development of clinical judgment that included the provision of adequate library resources; mentors and tutors who want to teach; adequate clinical experience and patient exposure; appropriate skills labs; and computer access had a universal commonality for all nursing students and nurses in the development of clinical judgment.
CHAPTER ONE
INTRODUCTION TO STUDY

As the practice of nursing increases in complexity, the development and use of clinical judgment skills in nursing has increased in importance for the provision of competent, safe nursing care (Chau, Chang, Lee, Ip, Lee, & Wootton, 2001; Tanner, 2006). Although clinical judgment and critical thinking are often described in the literature as somewhat ambiguous, sources agree that the processes are multi-dimensional and can be learned for use in nursing practice settings (Bradshaw & Lowenstein, 2011; Tanner, 2006).

In the past, nursing education concentrated heavily on the practical aspects of nursing with less attention paid to the theoretical aspects. However, Aiken, Clarke, Cheung, Sloane, and Silber (2003) conducted a study and concluded that the number of years of nurses’ experience was not a significant indicator of positive patient outcomes, while patient outcomes were significantly impacted by their degree of education.

Florence Nightingale, nursing’s most revered progenitor, intimated that the very being of a woman was the most essential ingredient of becoming a good nurse (Walker & Holmes, 2008). Nightingale lived and practiced in Victorian England, which nurtured a culture in which women were subservient to men. Women who lived during the Victorian Age were not welcomed or allowed in the medical profession; therefore all doctors were men. Since nurses were women, and by default, doctors were men, nurses were admonished to be obedient to doctors. Walker and Holmes (2008) traced the
continuation of that paternalistic culture in medicine through a review of nursing textbooks published between 1907 and 1969. Throughout the review, they found a continuing culture requiring obedience to doctors. In fact, one of the textbooks stated that the first duty of the nurse was obedience to the doctor. All of the textbooks surveyed emphasized the practical aspects of nursing education while they deemphasized the intellectual and theoretical aspects of nursing. In the late 1940s nursing was still viewed as a “handicraft” (Walker & Holmes, 2008, p. 114). Nursing textbooks in the 1960s and into the 1980s expounded upon nursing as a practice discipline and maintained that a nurse was first and foremost “a woman embodying the highest virtues of care and self-sacrifice” (Walker & Holmes, 2008, p. 115). Those authors concluded that until very recently, nursing education did not encourage or take into account “intellectual ability, scholarly endeavor, analytical and critical thinking, and problem-solving skills” (p. 115). Much of the view of nursing as a handicraft and not as an intellectual endeavor was fastidiously promoted by the medical profession to keep nurses less educated than doctors. Other than Florence Nightingale’s Notes on Nursing, most nursing textbooks from 1907 to 1969 were written by doctors (Walker & Holmes, 2008).

With the emergence of nursing as a distinct, scientifically based profession, the theoretical, intellectual side of nursing is now being promoted. Ninety-two percent of all nurses graduated from three year diploma programs in 1950. By 2001, 36 percent of nurses graduated from baccalaureate programs, 61 percent graduated from associate degree programs, and only three percent graduated from three year diploma programs (Aiken et al., 2003). By 2008, the number of diploma nurse graduates risen to 13.8
percent but baccalaureate graduates still held to 36 percent. The percent of nurses who held Master’s or doctoral degrees in 2008 maintained at 13.2 percent (AACN, 2012).

Unfortunately, the current nursing education system in Tanzania, East Africa, resembles the earlier system described in the Walker and Holmes’ (2008) review. As an example, the national curriculum for nursing education is currently being revised by a board which consists mainly of doctors and non-nursing individuals. In a perusal of the library at Machame Nursing School, Machame, Tanzania, many of the reference books as well as nursing textbooks were dated from the 1970s and the early 1980s. These are the same type of textbooks that were referenced by Walker and Holmes in their review of nursing textbooks. However, also at Machame, there was an emerging acknowledgement that a nurse was more than a being subservient to doctors’ orders. Nursing care involves not only a practical side but also includes the application of evidence-based knowledge and practice (Cody, 2003). Clinical judgment, as included in nursing education, has also been acknowledged as being vital to positive patient outcomes. Conventional wisdom no longer conveys the idea that nursing experience is more important than education levels (Aiken et al., 2003).

Tanzania is also facing a human resource crisis in the health care sector. A number of factors contribute to the poor health and social welfare situation as a result of the human resource crisis facing the country, particularly in nursing. The public health sector suffered extensively from the loss of experienced and skilled health workers due to the HIV/AIDS epidemic. Gustav Moyo, Registrar of the Tanzania Nursing and Midwifery Council, estimated that nurse staffing levels throughout the country average 35% of capacity (personal communication, 2011). Manzi et al., (2012) found in their
study that in 127 surveyed Tanzanian health facilities nurse staffing was at 14% of capacity. Moreover the health care sector has faced the problem of weak planning and forecasting of human resource requirements.

Tanzania has continued educating health workers of different cadres that include nurses; however enrollment of students in nursing school has continued to be low, compared to the needs of the country. As existing nurses reach retirement age, the need for new nurses will only grow. The Millennium Development Goal (MDG) created by the Tanzanian government aims to reduce infant and maternal mortality rates; combat HIV/AIDS, malaria and other diseases; and control them by year 2015. In order to meet MDG there must be concrete development plans to increase the number of nursing colleges to curb the current deficits.

In 2008, the construction of a modern Western style hospital was completed and staffed in urban Arusha, Tanzania. The hospital was a departure from a traditional African hospital, particularly in the area of nursing. In traditional African hospitals, nurses’ roles are relegated to a position of strict adherence to the orders of the doctor. There are few expectations of autonomy in nurses’ thought processes or actions. Nurses are also supplanted by families in regard to activities of daily living (ADLs). The families are responsible for all of the ADLs with little supervision by nurses. For example, the family is responsible for providing food, as well as assisting in feeding the patient. The nurses were often assigned to tasks rather than to individual patients, which further exacerbates the absence of clinical judgment skills and promotes linear thinking.

Ebright, Urden, Patterson, and Chalko (2004) used a modified Human Performance Framework (HPF) to design interview techniques for a research project
concerning novice nurses. The Human Performance Framework interview gathered information about what was happening to the person who was being interviewed during any given situation. In this case, 12 novice nurses were interviewed about the circumstances surrounding near-miss and adverse events; a total of eight near-miss and adverse events were reported by the novice nurses in the study. After analysis, nine themes were identified within the incidents. One of the most predominant themes, appearing in all of the reported incidents, was “clinically focused critical thinking” (Ebright et al., p. 534). This theme defined the novice as having, or not having, the ability to recognize relationships between patient data and subtle changes in patients’ situations. The interviews established that novice nurses needed experience to enhance their clinical judgment skills. The study emphasized the importance of providing novice nurses with support from experienced nurses as well as continuing education to promote positive experiences (Forrest, Brown, & Pollock, 1996). The promotion of positive experiences will, in turn, enhance clinical judgment. An indication that clinical judgment skills had not been well developed in Tanzanian nursing education was evidenced in a young nurse who worked on the orthopedic ward of the hospital in the following observation. Two nurses, one who had a Tanzanian educational background, the other who had a Western educational background, entered a patient room housing two pediatric patients. The Tanzanian nurse went directly to her patient, glancing at the other patient in the room as she passed by. The nurse who had the Western educational background also glanced at the other patient while passing by and noticed that the child “just did not look right”. Even though this patient had not been assigned to the nurse, the second nurse was familiar with the procedures that had been performed on the child and
from past experience knew the possible complications attendant to the procedures. Upon assessment, the child was found to have a temperature of 103 degrees Fahrenheit with swelling around the cast on his lower left extremity.

**Problem Statement**

There is a dearth of research concerning instruction of clinical judgment skills of nurses who actively work as nurses. The vast majority of research regarding this subject has been conducted in academic settings; tools that have been developed to measure clinical judgment have been created and used exclusively in academic settings. The importance of the provision of clinical judgment skills instruction to nursing students is undeniable. However, it is equally important to provide those same opportunities to nurses who are working and whose education did not include the acquisition of clinical judgment skills through education.

The education system in Tanzania has not lent itself to the development of critical thinking and hence, the development of clinical judgment skills in nurses, thus, the inclusion of clinical judgment skills appears to be absent in many areas of nursing education in Tanzania. Classroom and clinical nursing instruction in Tanzania currently relies heavily upon learning by rote memorization; little time is spent promoting independent thinking which negates the development of critical thinking and hence clinical judgment. As the profession of nursing continues to evolve in Tanzania, it has become apparent that formal education programs that address clinical judgment skills need to be developed for practicing nurses in the hospital setting as well as for nursing students to ensure that safe patient care will be provided.
Purpose

There were two purposes for this study. The first one was to investigate the perceptions of nurses regarding their educational experiences regarding the use of clinical judgment skills. The second purpose of the study was to ascertain perceived benefits and obstacles regarding appropriate approaches to the development of clinical judgment skills in nurses who work in a 125 bed urban hospital in Arusha, Tanzania.

Research Questions

The research questions for this study were:

1. What were the perceptions of practicing Tanzanian nurses regarding their educational experiences concerning the use of clinical judgment skills?
2. What were the perceptions of practicing Tanzanian nurses regarding the provision of appropriate approaches to the development of clinical judgment skills in an educational setting in Arusha, Tanzania?

Organizing Framework

The research design of this study was phenomenology; hence the organizational framework of this study was based on the concept that specific facets of nursing could be analyzed (Polit & Beck, 2012). Research questions were developed within this conceptual framework that explored the perception of ten (n=10) practicing Tanzanian nurses concerning the development of clinical judgment skills. Benner et al. (2009) provided the underlying definition of clinical judgment as the way in which nurses ascertain the holistic condition of their patients and how the nurses respond to those conditions. The nurses included in the sample for this study participated in interviews during which their perceptions concerning the development of their own clinical
judgment were explicated. The interviewees were also queried concerning the benefits and obstacles in the development of clinical judgment in nursing students.

Benner et al. (2009) provided the framework which was utilized to conduct this study. Five interrelated facets of clinical judgment contributed to the creation of research questions, instrumentation, data collection and data analysis procedures. The first of these facets is, the nurse displays an inherent attitude toward what is good and correct. Second, in-depth, comprehensive knowledge is relied upon. Third, the nurse depends upon the context of the specific situation and her emotional responses to that situation. Fourth, the nurse uses intuition in using clinical judgment. Fifth, narrative is used to express the human understanding of the condition of the patient (Benner et al., 2009).

The data gathered from the interviewees in this study held true to the framework laid out in Benner et al. (2009). Through the interviewees’ accounts it became apparent that their understanding of clinical judgment included all five aspects of clinical judgment as presented by Benner et al. (2009).

**Definition of Terms**

The following term was defined for purposes of this study:

- **Clinical judgment skills**: Those skills that a nurse uses to ascertain patients’ medical or nursing requirements which are based on that knowledge whether to take actions, using standard nursing applications or modifications of those applications, based upon the patients’ responses (Tanner, 2006).

**Assumptions**

It was assumed that nurses in the study would be available to participate in the study during their work hours. It was important to conduct the interviews during work
because of the requirements of Tanzanian labor laws which prescribe that work related interviews be conducted during working hours. It was assumed that the participants were forthcoming and truthful in their responses during the interviews.

**Limitations**

Limitations of this study included the possibility that the interviewees’ responses were affected by the interviewer who was male, White, and may have been considered an elder by the interviewees. In the Tanzanian culture, elders are given great deference (Juntunen, Nikkonen, & Janhonen, 2002). Hence, the participants’ answers may have been skewed toward what they believed the interviewer wanted to hear. Nursing is practiced in English in this setting; however, the nurses were more fluent in Kiswahili, which may have limited the participants’ understanding of the interview questions. The recorded interviews needed to be transcribed by a transcriptionist in Tanzania who was familiar with the interviewees’ accents as these accents may have been confusing to a transcriptionist in the United States.

**Significance of the Study**

There has been a lack of instruction in clinical judgment skills in existing nursing curricula in Tanzania; nurses in the Arusha hospital setting have had little access to such instruction. The study can be utilized as a first step toward instruction of clinical judgment skills for nurses. The Tanzania Nurses and Midwives Council (TNMC) of the Ministry of Health and Social Welfare of Tanzania can use this study as the first steps in the process of incorporating clinical judgment skills development in the government prescribed *Curriculum Information for Ordinary Diploma Programme in Nursing (NTA Level 4-6)* (2009) and in the *Minimum Standards For Nursing Practice In Tanzania*
Educators must develop appropriate strategies and teaching methods to include clinical judgment in their curricula in this country to meet patients’ emerging needs. The institution through which this study was proposed to be conducted was also formulating plans for a College of Nursing. The results of the study will be vital in the development of the curriculum for this endeavor.

The data obtained from this study will ultimately be useful to all nursing educators and hospital administrators. The data will be useful for nursing educators and hospital administrators in Tanzania because the medical and nursing professions in Tanzania are evolving at an ever increasing pace particularly in the participating hospital and nursing school. In order to provide educational opportunities to increase these clinical judgment skills in practicing nurses, appropriate programs must also be developed. Individual nurses can use this study to prompt their institutions to include the development of clinical judgment as part of in-hospital Continuing Nurse Education, which will enhance the nurses’ abilities to more effectively care for their patients. It was assumed that the product of this research will be of value in the creation of a curriculum to develop clinical judgment skills for practicing Tanzanian nurses in the hospital setting.
CHAPTER TWO

REVIEW OF LITERATURE

This chapter consists of the review of literature which is comprised of discussions of several topics of interest to this study. Topics included in this chapter address critical thinking and clinical judgment; research in clinical judgment; and in-hospital education. This study will be conducted using a population of Tanzanian nurses. One of the challenges that will be faced in this research is the difference in cultures of the researcher and subjects for this study. Hence, an in-depth review of the literature concerning cultural appropriateness in effective educational methods is also included.

Clinical Judgment

**Critical thinking and clinical judgment.** The importance of critical thinking and the development of clinical judgment have been well established in several professions. Moreover, both of these attributes have been identified as being vital in the development of expert nurses (Benner, Tanner, & Chesla, 2009; Facione & Facione, 1996; Tanner, 2006). In much of the literature, the terms clinical judgment and critical thinking have become interchangeable (Benner et al., 2009; Tanner, 2006). The majority of early research concentrated on critical thinking with clinical judgment as a facet of that critical thinking. In 1990 the American Philosophical Association convened a panel of 46 experts in critical thinking theory and research (Facione, 1990). Using the Delphi Method, this panel of experts defined critical thinking as having six definitive skills along with several sub-skills. These skills included 1) interpretation, 2) analysis, 3) evaluation,
4) inference, 5) explanation, and 6) self-regulation. The panel produced several recommendations, two of which dealt with specific education in and evaluation of critical thinking as well as means to include critical thinking in curricula.

Facione and Facione (1996) further refined the findings of the panel and stated that critical thinking was an important component in the development of nursing clinical judgment. The Delphi Project proposed that the ideal critical thinker possessed the following qualities: 1) truth-seeking, 2) open-minded, 3) analytical, 4) systematic, 5) self-confident, 6) inquisitive, and 7) mature (Facione, 1990). Facione and Facione (1996) used these qualities and posited that a nurse must be fair-minded in interpreting, analyzing and evaluating new evidence to make well founded inferences concerning that evidence. The nurse must also have the strength of character to accept input from other disciplines as well as to advocate for patients.

Utilizing the information from the Delphi research, Facione and Facione (1996) developed the Holistic Critical Thinking Scoring Rubric (HCTSR), the Framework for Externalizing Critical Thinking (FECT) and a Pedagogical Guide for Modeling and Nurturing Critical Thinking (Guide). The HCTSR is used to assess critical thinking by assigning scores to the individual’s thinking and actions. The FECT provides a construct that can be used to evaluate critical thinking through a series of questions that must be answered by the participant. The Guide would seem to be the most applicable to critical thinking and clinical judgment in nursing. The Guide can be designed to evaluate critical thinking at different stages of nursing education by increasing the degree of difficulty presented in the vignettes (Facione & Facione, 1996). All three of these tools were
designed to facilitate the observation and evaluation of critical thinking and hence, clinical judgment.

For the purposes of this study, clinical judgment will be treated as distinct from critical thinking and not as a component of critical thinking. Tanner (2006) stated that clinical judgment was specific to nursing; this concept better fits the questions to be asked in this study. Facione and Facione (1996) concluded that critical thinking in nursing is “purposeful, self-regulatory, a human cognitive process” (p.130). However, there is evidence that critical thinking is not purposeful and is not analytical. Norman, Young, and Brooks (2007) supported the premise that clinical judgment was dependent on the nurses’ experiences and non-analytical thought processes. Benner, Tanner, and Chesla (2009) endorsed this premise, noting that in many instances, experienced nurses reacted to their patients based, in part, on slight changes in clinical presentation combined with significant facts and experience many times without conscious thought.

**Research in clinical judgment.** Clinical judgment is a vital skill that must be developed quickly in nursing. Nurses are often primary care-givers who can notice and act on life-threatening changes in their patients (Etheridge, 2007). Without critical thinking leading to clinical judgment, the professional nurse would be little more than a technically trained staff member (White, 2003). Several qualitative research projects found that the recognition of patterns in patients’ symptoms and the patients’ responses were essential to clinical judgment (White, 2003). White (2003) utilized Heideggerian phenomenology and hermeneutical analysis to design a study of how fourth-year nursing students learned clinical decision making. A sample of nursing students, containing sixteen females and one male was interviewed concerning their clinical decision making
skills during a six week rotation on a critical care unit. The research team then coded the recorded interviews using the hermeneutic interpretive process. Five themes relating to the students’ clinical decision making skills that were identified from the data included 1) increasing confidence in skills, 2) deepening relations with experienced staff, 3) connecting with their patients, 4) developing self-confidence as a nurse, and 5) connecting to the clinical situation. Of these five themes, students rated deepening relations with experienced staff as the most important theme. The students believed that their relationships with other nurses enhanced the attainment of the other four themes (White, 2003).

It is only vaguely understood precisely how to attain the skill of clinical judgment (Etheridge, 2007). In an attempt to understand how nurses gain this skill, Etheridge (2007) interviewed nurses who had recently graduated from baccalaureate nursing programs, were no longer serving internships and were practicing without preceptors. Three separate interviews were conducted with each participant. The first interview took place one month after the nurses were no longer with preceptors. The second interview occurred two to three months later and the final interview was conducted approximately nine months after the first interview. The main question asked in each interview dealt with “making nursing clinical judgments” (Etheridge, 2007, p. 25). However, the author found that this phrase was confusing to the subject and was changed to “think like a nurse” (p. 15). The four themes that emerged from the interviews were 1) development of confidence; 2) accountability for one’s decisions and actions; 3) relationships with other staff; and 4) thinking critically. The nurses reported that the most important aspect of learning how to think like a nurse or the development of clinical judgment was
experience. These experiences were not exclusive to clinical experience, but also included experiences with other staff members. As the nurses gained experience and were guided in their decision making by more experienced staff, the confidence in their own clinical judgment skills increased.

Luker and Kenrick (1992) conducted a quantitative study that investigated what influenced nurses’ clinical decision making processes. A convenience sample of 45 experienced nurses and two nursing students was recruited. During the first step of the study, the researchers observed 17 nurses in their practice settings to identify areas to explore during the interviews. Five areas that were established for the interviews from these observations were 1) area of practice; 2) specific rationale and factors which influenced clinical decision making; 3) general factors that influenced clinical decision making; 4) current research and practice knowledge; and 5) how the nurse felt about an expansion of scope-of-practice. Categories concerning the sources which influenced decision-making were then generated from the interviews. These categories included knowledge based upon 1) research, 2) experience, and 3) common sense or intuition. Approximately 57% of the interviewees believed that experience had the greatest influence on their clinical decision making skills.

A mixed-method research approach utilizing both qualitative and quantitative data gathering techniques was the basis for a study conducted to ascertain factors, both human and environmental, that affected the decision making process of registered nurses (RNs) (Ebright, Patterson, Chalko, & Render, 2003). A sample of eight experienced RNs was recruited. These RNs all worked in some facet of acute care nursing. A second sampling was conducted based on the findings of the first sample of RNs. This sample reflected
the areas of interest that would be included in the study. Each of the subjects was then observed for three hours on two separate occasions. The manually recorded observations were then entered into timeline software, which was used to guide subsequent interviews. Critical Decision Method interviews were conducted one week after the last observation. These interviews dealt specifically with instances in which the RNs were observed in situations that required making clinical judgments and acting upon them in response to new patient situations (Ebright et al., 2003). Codes based on the Sharp End and Blunt End Framework were then used by an expert panel to code the interviews; several patterns emerged. Chief among them were “knowing individual patient information…knowing typical patient profiles… anticipating or forward thinking… (and) proactively monitoring patient status” that could guide the subject nurses’ work (pp.635-636). The authors found that only experienced nurses could demonstrate all of these patterns.

The importance of the link among nursing experience, clinical judgment, and critical thinking is well established in the literature. In those instances where much of previous nursing experience was not valid in a new setting, nurses must receive instruction in clinical judgment skills in the new setting. Some of the nurses who will be included in this study have extensive experience. However, that experience occurred in a traditional Tanzanian hospital. Since the author’s research will be dealing with nurses who are employed in a Western style clinical setting, in-hospital education must also be anticipated.
**In-hospital Education**

The vast majority of research concerning education and clinical judgment has been conducted in the traditional school setting with nursing students. However, in a project performed by Hyrkas, Tarkka, and Paunonen-Ilmonen (2001), healthcare teacher candidates conducted intensive instruction in self-reflection to nursing students in a large university hospital in Finland. The Delphi Project established that three of the skills of a critical thinker or for use in clinical judgment include interpretation, analysis, and evaluation (Facione, 1990). All of these skills were used in self-reflection, but self-reflection is not an inherent process as it was found that it needed to be taught (Hyrkas et al., 2001). In the Finnish project, teacher candidates were taken into the hospital setting in order to better facilitate teaching the self-reflection process. The candidates planned and taught modules as needs arose in the clinical setting. Normally, in Finland, healthcare is planned and taught in accordance with only a formal curriculum in mind; this same model is used in Tanzania. Very little teaching is conducted in the hospital settings in either country. The new model, teaching in the hospital setting and following needs as opposed to formal curriculum, gave the teacher candidates and the nurses the opportunity to collaborate with each other. Through this collaboration, the nurses could understand the importance of self-reflection in their practices. The importance of this project to the author’s research lies in the fact that the project was completed in a hospital setting outside of the United States. Finland is not a developing country, but its nursing system more closely resembles that in the Arusha hospital in which the author’s research will be conducted.
Murphy (2004) reinforced the concept of teaching self-reflection in a study of 33 student nurses. Students who had instruction in self-reflection scored significantly higher in clinical judgment than did students who had no training in self-reflection. Although this research was conducted with students, it took place in clinical settings. Findings had importance for in-hospital education of experienced nurses through implications extrapolated from the data. Those implications included 1) encouraging nurses to reflect on their nursing practices, 2) the sharing of experiences, 3) that nurses could be instructed in the techniques of self-reflection, and 4) the realization that ways to promote nursing expertise may not need to come from the academic side of instruction (Murphy, 2004). This last implication is of importance to the author’s research since nursing education in Tanzania at all levels relies almost exclusively upon the teaching of theory by rote memorization.

The importance of education in the clinical setting became apparent in the study conducted by Forrest, Brown, and Pollock (1996). This study was conducted in Scotland where the model of nursing is very comparable to the model to which nurses in Tanzania aspire. Thirteen staff nurses and 30 nursing students participated in a qualitative study that sought to better define the role of nurse educators in the clinical setting. Data was collected in two phases; the first phase consisted of semi-structured interviews. The second phase consisted of eight focus group interviews. The data gathered in these two phases were then analyzed using the grounded theory approach. Several criteria emerged, but major among them was the crucial aspect of “realistic teaching” in the clinical setting (Forrest et al., 1996, p. 1261). This finding is particularly critical in the Tanzanian setting since virtually all of nursing education is theoretical and very little is
practical. This study also found that the majority of the participants believed that nursing educators should also be practicing clinical nurses. Although Tanzanian nurses have a high regard for educators, they are much more receptive to instruction from nurse educators who can demonstrate practical knowledge in the hospital setting. An important conclusion of this study is centered on the proposition that in-hospital nurse educators should be flexible and not adhere to institutionally defined criteria. The educators’ roles should develop from the nurse educators’ relationships with the staff and students with whom they are dealing.

As the profession of nursing becomes more complex and the body of knowledge needed in the practice of nursing broadens, the demonstration of competency and prowess in nursing can be achieved through continuous professional development (McCormack & Slater, 2006). One study investigated the importance of the clinical education facilitator (CEF) in maintaining a high degree of in-hospital education. This study was conducted in the United Kingdom, the country from which Tanzania draws its nursing and medical models. A realistic evaluation methodology was used to ascertain the relationships between CEFs and systems then in place; the contexts in which those relationships existed; and what outcomes could be expected from the relationships that existed within the contexts. A random sample of 105 nurses from seven different institutions with CEFs in place was recruited. Individual interviews were conducted, as well as focus groups; in addition, a survey was used to ascertain what the nurses considered indicators of a good learning environment. The qualitative data were used to formulate the survey. Responses of the survey were then quantified to conclude the importance of CEFs. At all levels of nursing, the findings indicated agreement that CEFs
were needed to facilitate education and training. The importance of this study to the author’s research has to do with the fact that the Matron (Director of Nursing) of the hospital is presently in charge of nursing education within the hospital. Because of the Matron’s expansive workload, nursing education has taken a very low place in her priorities. McCormack and Slater (2006) provided the basis for the establishment of a stronger role for an independent CEF in the structure of the institution. This change in turn would assist the institution in providing nurse education opportunities in consistent clinical environments instead of shifting from ward to ward as the Matron is called upon to cover her other responsibilities (White, 2003).

**Cultural Competence**

In some respects Tanzanian culture mirrors Western culture. Medicine, and hence nursing, is practiced in English. As stated previously, the medical and nursing models are patterned after the English model. However, in a personal communication, Jacobson (2006) stated that in medicine as well as daily life, Tanzanian culture might have one foot planted in the modern world, but the other foot is firmly planted in the past. The literature did give some clues concerning remaining culturally appropriate as one conducts research.

The educator, or researcher, must develop an awareness of the culture with which one is dealing (Luquis & Perez, 2003). This awareness could be somewhat problematical since there are no resources available that can be used to help familiarize one with the myriad of cultures and sub-cultures in a country like Tanzania. However, cultural competency can be described as a frame of mind. The researcher must be well grounded in his own beliefs and culture and must also be receptive to differences in other cultures.
(Berry-Caban & Crespo, 2008; Iddi-Gubbels, 2006; Luquis & Perez, 2003; Wlodkowski & Ginsberg, 1995). There must also be a willingness to extend oneself beyond the expected and accept what sometimes might be outside of one’s comfort zone (Luquis & Perez, 2003).

Cultural dissonance must be addressed prior to effective communication. For example, Berry-Caban and Crespo (2008) pointed out that an area of dissonance might be the difference in views of personal and professional lives. In Western cultures, there is a tendency to separate one’s personal and professional lives; in East Africa, the opposite is true. One’s personal life is subsumed by one’s professional life. Another example of possible dissonance might be concepts of family structure. In the West, monogamy is the prevalent family structure while in many areas of the world, including Tanzania, polygamy is quite common. The importance of cultural competence within nursing practice, research, and nursing education cannot be stressed enough. For this research, the ability to communicate was paramount. Since the research was based upon interviews of Tanzanian nurses, it was essential that the researcher was culturally competent in gaining and exchanging information and building relationships with the subjects of the research (Berry-Caban & Crespo, 2008; Wlodkowski & Ginsberg, 1995).

Summary

The importance of clinical judgment is well established in nursing literature (Benner et al., 2009; Facione & Facione, 1996; Tanner, 2006). There was some discussion of differing definitions for clinical judgment, one of which described the phenomenon as objective and analytical. However, this literature review dealt with the school of thought that clinical judgment is more subjective and less analytical (Benner et
Researchers of clinical judgment have developed interview techniques that can be used to identify the depth and breadth of nurses’ clinical judgment skills (Ebright et al., 2003; Ethridge, 2007; Facione & Facione, 1996; White, 2003). These techniques are important to continued research into the development of clinical judgment skills in novice as well as experienced nurses.

The development of clinical judgment skills in the clinical setting is important even though much of the nursing literature dwells on developing clinical judgment skills in an academic setting (Forrest et al., 1996; Hyrkas et al., 2001; McCormack & Slater, 2006). Self-reflection and self-assessment are fundamental skills that must be learned in order to better develop clinical judgment skills (Murphy, 2004). Since this study will be conducted in Tanzania, cultural appropriateness was addressed in the review of nursing literature as a component of the study as well as the future development of clinical judgment skills in nursing curricula in that country.
CHAPTER THREE

DESIGN AND METHODOLOGY

Qualitative research centers on the way in which individuals perceive and interpret the world (Polit & Beck, 2012). Qualitative research also explores how individuals produce meaning out of their lived experiences (Baker, 2006). Interviews of two nurses from each of the five departments at Arusha Lutheran Medical Centre would provide their perceptions of their first experiences in an educational setting with the use of clinical judgment. The interviews would also give the interviewees the opportunity to state their perceptions of the benefits and obstacles in the development of clinical judgment skills. Since culture is based in the beliefs and behaviors of individuals in a society, it would be imperative that the views of individuals and their lived experiences would be sought.

Research Methodology

Qualitative research gathers the spoken experiences of the research subjects and then is used to analyze those words in order to explain in detail the phenomenon that is being studied (Creswell, 2008). Emphasis is placed on exactly what the phenomenon means to the individual experiencing the phenomenon (Polit & Beck, 2012). In this case, the phenomenon was the perception of Tanzanian nurses’ experiences with clinical judgment in their education as well as their thoughts concerning the development of clinical judgment skills during continuing education sessions in hospitals as well as post graduate education.
Research Design

This study dealt with the lived experiences of a group of Tanzanian nurses; hence the qualitative methodology that was utilized in this study was phenomenology. Phenomenology can be defined as the study of lived experiences, or how the quality of those experiences can impact an individual’s existence (Polit & Beck, 2012; Smith, 2008). Thoughts, perceptions, memories, emotions, desires, and social interactions are a few of the types of experiences open to phenomenological study. Max van Manen provided a most appropriate model of phenomenology which gives much more concrete guidelines for research (as cited in Earle, 2010). Van Manen’s model focuses on educational practices and their improvement. Van Manen broke his model into six separate activities: 1) the phenomenon is one of interest to the researcher; 2) the research studies something that is lived and not merely visualized; 3) the basic character of the phenomenon is considered; 4) the phenomenon is chronicled through the written word; 5) the principle phenomenon is the central theme; and 6) particular parts of the study should be allowed to develop during the research process.

This study looked at the appropriateness of promoting clinical judgment in a group of Tanzanian nurses whose first-person experiences were primary in defining the overall culture of the group. The nurses came from different tribal experiences, several different nursing schools, and worked in different areas of the hospital. All of these experiences, or phenomena, were taken into consideration and a gestalt was formed that could be utilized to formulate a curricula for in-hospital instruction in clinical judgment skills and in nursing education programs, as well as the Tanzania Nurses and Midwives Council of the Ministry of Health and Social Welfare for inclusion in the prescribed
government nursing curricula. Van Manen’s model (as cited in Earle, 2010) was of particular value in this study since the central aim of the study was to use the lived-experiences of the subject nurses to help develop appropriate educational approaches to teaching clinical judgment skills.

**Population and Sample Selection**

The choice of participants and a unique sampling method are crucial in qualitative research so that the highest degree of quality in research is maintained (Draper & Swift, 2011). In this study non-probability sampling was used. This type of sampling does not use random selection methods and is used to arrive at a range of ideas or knowledge that people possess (Emmanuel, n.d.). This characteristic makes non-probability sampling particularly well suited to phenomenological research. As a sub-category of non-probability sampling, purposive sampling methods were used in the selection of participants for this study. Purposive sampling is subjective in nature and is used to select participants who might be best able to address the research aim (Guest, Bunce, & Johnson, 2006; Marshall, 1996). The researcher’s personal experience is vital in the selection process of purposive sampling (Gurste & Barrios, 2006; Trochim, 2006). Purposive sampling assumes homogeneity among the participants (Marshall, 1996). Selection of the participants for this study was determined by the researcher. Sample size is a consideration in qualitative research; however, the preponderance of the literature speaks to methodology and not the extensiveness of the sample (Sobal, 2001). Much of the literature also stated that sample size can be somewhat ambiguous (Draper, & Swift, 2011; Guest, 2006; Marshall, 1996; Morse, 1995; Trochim, 2006). This ambiguity leads to some difficulty since most research protocols require stating the number of participants.
in the research proposal (Guest, 2006). Draper and Swift (2011) suggested that the sample size be large enough to answer the research question but not so large that the data would overwhelm in-depth analyses. Morse (as cited in Guest, Bunce, & Johnson, 2006) stated that for a phenomenological study, at least six participants be selected. Polit and Beck (2012) stated that in phenomenological research a sample size of ten is optimal. Thus, for this study the number of participants was restricted to ten (n=10); two nurses were selected from each of five departments of the hospital; the Operating Theatre, Obstetrics/Gynecology, Intensive Care Unit, Medical, and Surgical departments. Experience and level of nursing education were taken into consideration by selecting experienced nurses who had a three or four year degree and less experienced nurses who had a two year degree from each department. A letter of introduction and invitation (Appendix A) was given to each potential participant. This letter was provided in both English and Kiswahili (Appendix B). Ms. Janeth Itemba, MBA, the Hospital Administrator who is Tanzanian, provided all translations.

The study was conducted on the campus of a newly constructed, modern, 125-bed hospital in Arusha, Tanzania. In order to assure privacy and freedom from interruption, office space dedicated to this study was provided by the hospital. The office was located on the second floor of the hospital. Furnishings were such that a comfortable, safe atmosphere was promoted.

Interviews were held during the interviewees’ time of work because of labor policies. It is important to note that these labor policies are governmental and not generated by organizations such as unions. When Tanganyika, later renamed Tanzania, gained its independence, Julius K. Nyerere was elected as Tanganyika’s first President.
President Nyerere formed a government based upon socialist principles with great emphasis on workers’ rights. The labor laws of present day Tanzania are based upon those principles. It is unlawful to require a nurse to attend a hospital related function without remuneration. Hence, it was necessary to conduct the interviews during the nurses’ working hours.

**Measures for Protection of Human Subjects**

Prior to the collection of data, IRB permission was obtained from the University of Mary (Appendix C) and the Arusha Lutheran Medical Centre (Appendix D). Participants were informed of all of their rights as per University of Mary's mandates. An informed consent document designed for use in this setting was provided to each participant before the interviews proceeded (Appendix E). The informed consent document was provided in English as well as Kiswahili (Appendix F). The interviews were audio recorded and transcribed by a professional transcriptionist who was not acquainted with the interviewees and would have no contact with them. The interviewees were also informed of all of their rights as subjects in human research. They were informed that there would be no penalties to their employment status if they chose not to participate in the study and they had the right to leave the study at any time with no repercussions. The explanation of the participants’ rights was reinforced by the Matron of the hospital as well as the Medical Director of the hospital. This step was particularly important since in the past, nurses had been without autonomy and might be doubtful if they were not given those reassurances. Interviewees were assigned code numbers for identification. The key for the codes was maintained by the Medical Director of the hospital under lock and key and kept separate from the signed informed consent forms.
At the time of the interviews, the researcher made written fieldnotes. The researcher also maintained a personal diary in reference to the interviews. All fieldnotes and diary entries referred to interviewees by these codes. The transcribed interviews as well as interview data were maintained under lock and key in the researcher’s desk located in the locked Matron’s office. The author and thesis chair were the only persons who conducted the analysis of the raw data. Because the nursing staff and hospital campus were so small, it was impossible to hide the identity of participants in the study. The data was reported in aggregate and no names were used nor mention of departments. These protection measures were described to individuals who were invited to participate in the study prior to including them in the study.

**Instrumentation**

A semi-structured interview guide (Appendix G) was utilized to collect data for this study. The interview guide was specifically designed so that: interviews could be scheduled at a time in which nurses would be present at the hospital; pre-planned questions could be used; questions that might develop during the interview might be asked; and, the interview would last at least 60 minutes (Whiting, 2008). The interview guide was designed to lead the interviewee through the interview in a familiar and also coherent sequence (Polit & Beck, 2012). For example, the first question of the interview was one that all nurses are trained to answer when seeking employment, “Tell me about your life, from your birth to today.” This question was also designed to put the interviewee at ease since they were familiar with the question. All questions in the interview guide were designed as open-ended and to elicit more than just “yes, no,” or
short answers. The intent of the interview guide design was to draw the interviewee out and encouraged them to speak freely (Polit & Beck, 2012).

**Data Collection Procedures**

There was a possibility that since the researcher was male and was considered an elder in the culture, some of the younger nurses would be less than forthcoming in their responses. This situation was ameliorated by the inclusion of questions and statements that would put the nurses at ease. There was also the possibility that since the researcher had worked closely with many of the nurses, their responses would be influenced by previous experiences. However, this relationship might also work in favor of the study since these nurses were familiar with the interviewer. Communication may not have been as difficult since the interviewer was familiar with voice inflection and word usage.

In order that the researcher’s biases and experiences did not adversely affect the outcomes of the interviews, the researcher made entries in reflective fieldnotes on a daily basis which would then be regularly reflected upon. These reflective fieldnotes assisted the researcher in remaining reflexive throughout the study (Baker, 2006).

The interviews were conducted on site in a private but congenial atmosphere where there were no interruptions. Tea or coffee was offered to help put the interviewees at ease. The interview was meant to elicit personal responses to the questions that were asked, so establishing a less formal atmosphere was more productive. The researcher was also aware that the nurses may be a bit conflicted since they were taking time away from their usual duties. Interviews were conducted during the nurses’ work-hours since there were legal ramifications that have to do with labor laws if interviews were conducted during the nurses’ off-hours. The researcher knew some of the possible
interviewees for over ten years, so a relationship was well established. For those subjects who were new to the researcher, the Matron participated in introducing the interviewees to the researcher. This first introduction took place in the nurses’ departments and was less formal than an introduction done in the Matron’s office. A sense of camaraderie was attempted with all the nurse interviewees. A pre-interview checklist, as represented by Appendix H was used to explain important items to each interviewee.

Since this study had a distinct goal, each interviewee was interviewed once utilizing the semi-structured interview guide contained in Appendix G. Questions that were asked during the interviews were open-ended in order to elicit personal responses that helped answer the research questions that were posed for the study. Rather than utilizing a fully structured interview, a semi-structured interview mode was used. In semi-structured interviews, there are specific questions that must be answered. However, unlike structured interviews, in semi-structured interviews there is latitude in structuring the questions from one interview to another. The interviewer is also allowed the liberty to further probe responses to the listed questions (Draper & Swift, 2011; Whiting, 2008). The questions asked during the interview were about the nurses’ home village or town. A sub-question was the location of that specific village/town. This information was importance due to the differences in geographical cultures. For instance, the Maasai, who are nomadic livestock herders and have no established homes, have quite a different view of life than that of the Chagga, who maintain permanent villages on the slopes of Mount Kilimanjaro. Questions were also asked about the interviewee’s family concerning size, brothers and sisters, and extended family. However, unless proven important during data analysis, the primary reason for these questions was to put the interviewee at ease with
questions that were easily answered with familiar information. The next set of questions addressed the research question of personal obstacles that confront Tanzanian nurses. A segue to this information was to inquire whether the interviewee was married or had children. In the United States, these questions are either not permitted or politically incorrect; however, in Tanzania, this information is very important to one’s view of life. Some sub-questions dealt with day-care and other social support issues. If the interviewee was an experienced nurse, what working issues had arisen at previous institutions? Sub-questions dealt with comparing the present conditions to the past. Finally, questions that concerned the interviewees’ knowledge of clinical judgment were addressed.

**Field Notes**

Field notes were an important source of data for this qualitative study. Creswell (2008) described two types of fieldnotes, descriptive and reflective. Descriptive fieldnotes encompass what the interviewer sees during the interview, such as body language. Reflective fieldnotes might also be depicted as a personal diary that records the interviewer’s thoughts about what the interviewee has said and what interpretation might be derived. Both of these styles of fieldnotes will be used for this study and will become an integral part of the data analyzed.

**Data Analysis Procedures**

A professional transcriptionist was recruited who would have been fully familiar with both English and Kiswahili to transcribe the audiotaped interviews. The transcriptionist’s qualifications included acting as a transcriptionist for the United Nations International Criminal Tribunal for Rwanda for the past seven years. The
transcriptionist’s experience in transcribing testimony given by Rwandan, Tanzanian, and English speaking witnesses lent itself to the task of transcribing the interviews. The recorded interviews were provided to the transcriptionist daily. All transcriptions were read, and notes were made directly on each transcribed interview prior to any data collection. After the initial reading, each interview was coded using “lean coding” (Creswell, 2008, p. 252). A master list of codes from all interviews was then created and reduced to a manageable number. Categories, themes, and an assertion were developed from the coding that would best answer the research questions in the study. It was difficult to be more specific since, in qualitative research, more and/or different research questions might emerge from the data. The final analyses, representation, and reporting were completed in the United States as the analysis was conducted with a researcher from the University of Mary who was experienced in qualitative data analysis. Distractions in Tanzania were many, were constant, and would not have been conducive to intensive data analysis and writing.

**Validity and reliability.** Issues of validity and reliability in qualitative research have been a concern since the inception of qualitative research (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Validity has been a major component in the evaluation of quantitative research, particularly in the area of elimination of bias (Hannes, Lockwood, & Pearson, 2010). However, in qualitative research, bias is addressed through attention to criteria dealing with trustworthiness. The literature concerning validity and reliability in qualitative research is rife with differing opinions as to the importance of either concept in qualitative research. Rigor, trustworthiness, plausibility, and credibility are used interchangeably when describing validity in qualitative research (Polit & Beck,
For purposes of this discussion, trustworthiness was used as synonymous with validity and reliability. Rigor, or trustworthiness, as applied to research is that factor which when lacking, causes the research to lack value, to be useless, and possibly to be fictitious (Morse et al., 2002). Trustworthiness in qualitative research has been difficult to quantify, such that some well-known qualitative researchers have attempted to forego validity and reliability, stating that such concerns were better applied to quantitative research. Over several years a new paradigm of rigor has become prevalent in qualitative research, which focuses on the end product of the research (Morse et al., 2002).

Significance, impact, relevance, and utility of the research have seemingly replaced traditional rigor in the processes of research. Although significance, impact, relevance, and utility were all important reasons for conducting this qualitative study, measures of trustworthiness were followed.

Whittemore, Chase, and Mandle (2001) expanded upon Lincoln and Guba (as cited in Polit & Beck, 2012) whose description of quality in quantitative research is considered to be the gold standard. Whittemore et al. (2001) set out four primary facets and six secondary facets of qualitative research validity. The primary criteria include credibility, authenticity, criticality, and integrity; with secondary criteria including explicitness, vividness, creativity, thoroughness, congruence, and sensitivity.

Credibility and authenticity in qualitative research can be addressed through a commitment by the researcher to expend enough time and resources in data collection to fully satisfy the needs of the primary reasons for the study (Polit & Beck, 2012). The researcher in the proposed study had the personal and professional ability to commit to whatever length of time it would take to complete the study. This commitment is
evidenced by the past seven years spent assisting in building Arusha Lutheran Medical Centre, as well as establishing the Arusha Lutheran Medical Centre Nursing School. In order to further enhance credibility, the interview questions were designed to allow the research participants to fully express their lived experiences concerning clinical judgment skills.

Criticality and integrity were addressed throughout the study. One of the aspects of qualitative research which can be both a threat and an enhancement to trustworthiness is the ability of the researcher to modify the research as it is conducted. Morse et al. (2002) stated that the researcher’s ability to remain flexible, creative, and sensitive during the research and open to needed changes is vital to the rigor, or trustworthiness of the study. For example, if during the course of the interviews the researcher found that interview questions needed to be refined or added, the decisions and the reasons for those decisions would be detailed in the fieldnotes.

Explicitness and vividness were addressed via meticulous record keeping as well as the presentation of the results of the study (Polit & Beck, 2012; Whittemore et al., 2001). In the proposed study, interviews were recorded and available to the researcher at all times. Coding of the interviews began immediately. Field notes, taken during and after the interviews, were correlated with interviews immediately post interview.

Whittemore et al. (2001) stressed the importance of sensitivity as a criterion of validity in qualitative research. This study was conducted in Tanzania which necessitated cultural sensitivity on the part of the researcher. The interviewer/researcher had a background rich in years and experience in Tanzania which was invaluable in enhancing the study as it evolved. Using the instrument contained in Buckingham and Clifton
(2001), an evaluation of the researcher revealed the possession of the following attributes: 1) Learner, defined as a life-long love of learning; 2) Input, which places emphasis on inquisitiveness; 3) Relator, which has significance concerning relationships with other people; 4) Connectedness, a talent for looking for cause and effect; and 5) Intellection, which indicates a fascination with thought processes. All of these attributes are vital in maintaining integrity, sensitivity, and responsiveness needed in qualitative research (Morse et al., 2002).

One of the concepts of thoroughness is attention to sampling (Polit & Beck, 2012; Whittemore et al., 2001). Sample appropriateness is inherent since this study was concerned with the lived experiences of Tanzanian nurses and the clinical judgment established in their education. Sampling was conducted within a Tanzanian hospital and was not restricted to nurses born and educated in Tanzania. This lack of restriction was an important distinction since there were Kenyan educated nurses on the hospital staff. The sampling included nurses from all departments in the hospital, which gave as broad a spectrum as possible of experiences. The sampling also included attention to how recently nurses have come into the field of nursing, adding further depth to the data. Interviews were limited to one per nurse unless the investigator determined that additional interviews would have elicited important data.

Methodological coherence is used as a verification process that safeguards the correspondence between the research question and the research method thus enhancing the concept of congruence (Morse et al., 2002; Polit & Beck, 2012; Whittemore et al., 2001). In this study, the research questions dealt with the lived experiences of Tanzanian
nurses. The research paradigm used, phenomenology, is defined as the study of experiences that impact individuals’ lives (Smith, 2008).

Data were gathered and analyzed on a continual basis as interviews were conducted. Reliability of the transcriptions of the interviews was enhanced by the recruitment of a transcriptionist with extensive experience. The interviews were coded on a daily basis which allowed the researcher to adjust the study based on emerging needs, by constantly comparing accumulated data with newer data. The newer data were either confirmed or not confirmed as it was compared to the older data.
CHAPTER IV

FINDINGS

The findings that were gleaned from the interview data will be discussed in this chapter. This study was conducted to ascertain the perceptions of a sample of nurses regarding their educational experiences regarding the use of clinical judgment skills. The discussion in this chapter will include background information of the nurses that was elicited during the interviews as well as presentation of the data that were collected during the interviews.

Background Characteristics of the Sample

A sample of ten (n=10) nurses was chosen for this study. The researcher used a non-probability, purposive sampling method to obtain this sample. Two nurse interviewees from five departments in a 125-bed hospital located in Arusha, Tanzania, were selected. At the time of the interviews, only one of the interviewees was an Enrolled Nurse. The Tanzanian Enrolled Nurse program consists of three 22 week semesters of general nursing education, plus one 22 week semester of midwifery. Two of the interviewees initially received certification as Enrolled Nurses but had been promoted to Diploma Nurses because they participated in education programs within the last six to seven years. Seven of the interviewees had completed four year nursing education programs which qualified them as Diploma Nurses. Over the course of several years, the Tanzanian Diploma Nurse program has changed from a four academic year program to a
three academic year program. At least one of the academic years in the Diploma Nurse program is spent in a sub-specialty, which is usually midwifery.

The ranges of the interviewees’ ages were as follows: two interviewees aged from 20–29; five interviewees aged from 30–39; and three interviewees aged from 40–49. The researcher believed that this sample was representative of the general nursing population. Nine of the interviewees were female and one was male. Eight of the interviewees were of Tanzanian lineage and received their secondary education in Tanzania, while two of the interviewees were of Kenyan lineage and received their secondary education in Kenya. Interviewee Two gave the following reasons for leaving Kenya to become a nurse in Tanzania:


Okay, life was not so good, my parents were so poor by then, and we had nothing. Okay, to improve ourselves, to maybe go for higher learning. So I had to wait until God made a way. In 2004 there is a new course, the way you want to start, in the University of Arusha [Tanzania]... And so they had requested people to come for interviews... they selected people that they wanted. So I was lucky because I was the pioneering class. [The University of Arusha is a Seventh Day Adventist institution that offered a few scholarships to their nursing school.] (personal communication, October 30, 2013)

The interviewees’ years of experience ranged from 2 to 18 years. It is important to note that two of the Diploma Nurses (RN) began their careers as Enrolled Nurses (ENs) with eight and thirteen years of experience as ENs. The lone EN interviewee had also received post graduate education in guidance and counseling. The interviewee who
had 18 years of experience also had a post graduate certificate in Operating Theatre Management. With the exception of the above two interviewees, midwifery was the sub-specialty for the rest of the sample. Seven of the interviewees had been born, raised, and educated through secondary school in rural areas of Tanzania that stretch from central to northwestern Tanzania. There was no commonality found in the interviewees’ choices of nursing schools.

**Presentation of the Data**

An analysis of the transcripts of the interviews revealed four major categories. These categories represented the interviewees’ perceptions concerning the use of clinical judgment skills. Using the interviewees’ own words, the categories that were identified were: The Patient First; Thinking More; Attending the Patient; and What, What, What. Through analysis of the data, codes, categories, and themes, the final assertion for the study was identified. Figure I is a representation of the connectedness of those codes, categories, and themes that lead to the final assertion.
Figure 1. The relationship between Codes, Categories, Themes and Final Assertion

**Codes:**
“Hear the patient needs…at that moment”
“…the action of going and asking patients…”
Presence with patient
Patient engagement
“Relieve them”
“I can diagnose…it’s a clinical judgment”
Cooperation
“What can I help this patient”
“Process of communication takes a time.”
“Let’s help the patient”
 “…my heart was totally to stay with the patient”
“Can’t pass off “responsibility”
“Every individual has…is unique”

**Category:**
Patient First

**Theme:**
The interviewees related a strong professional nursing responsibility to help patients when deviations in their statuses were perceived. When confronted with these deviations, they did not shirk their responsibilities by persuading someone else to assume those responsibilities. Interviewees described the use of an authentic nursing presence to identify situations in which clinical judgment skills were used.

**Codes:**
“You need to think of something to do”
“When you observe you can find where to start”
“…judge patient”
“Identify danger signs”
“You can see something”
Identify the patients’ needs
Be alert to signs
Intuition
“I’ve seen the general appearance of the patient”
Process of elimination
Independent judgment
“Judge then take risks”
“Immediate action which can be done at that time, yes”
Immediate care
“Helps nurses to act”

**Category:**
Thinking More

**Theme:**
The interviewees described the use of clinical judgment skills using actual experiences from their practice. Interviewees related their intuitive processes and the steps they used in patient situations that required clinical judgment skills.

**Assertion:**
All of the interviewees described phenomena from their own practices to illustrate both successful and unsuccessful uses of clinical judgment. From their experiences, the interviewees were able to identify obstacles to the application of their clinical judgment. In a culture where females are deemed subservient, the interviewees showed great strength and perseverance in the use of clinical judgment in their practices. The interviewees stated that experience in the clinical setting was of exceeding importance in the development of clinical judgment in student and junior nurses. The interviewees provided insights into the personal and professional characteristics necessary to fully develop and apply clinical judgment skills.
Codes:

Personal Characteristics:
“By God’s grace, I was blessed”
“Depends with the character of the nurse.”
“What should I do now to help this patient”
“I care for them”
Open Serving
“…and out of the experience…I understand”
“The nurses are a calling”

Professional Characteristics:
“…the first thing, you must be faithful”
“I care for them…in case I fall sick…”
Patient centered
Advocate
“Identify needs of the patient before others”
“Therefore it’s your responsibility”
Competent
Organized
“But we chip in and tell them (students), do it.”
“…understand, nursing is a profession.”

Category:

Attending the Patient
Themes:
The interviewees identified personal and professional characteristics of nurses who demonstrate clinical judgment skills. Stories that related successful and unsuccessful use of clinical skills gave rise to these identifiable characteristics.
“And many of them…there is not a calling…they come as a job,” referred to many junior nurses.

Category:

Two Way Process for School and Staff:

“…not readily done by new graduates”
“I can offer to supervise them”
“…she (tutor) should understand what kind of students she has.”
“Good supervisor…close monitor”
“to show them the direction”
Assess Learners, Mentors, and Tutors
“…find skilled clinical instructor in clinical area”
“Experienced Nurse teacher”

Clinical Applications

Combined with Theory:
“…we should not laugh at them…show them the direction…so as to succeed”
“Show how to do things”
“Every person needs a different approach”
Application
“Know how to judge”

Category:

Themes:
The interviewees stated that in order to properly develop clinical judgment skills in nurses or student nurses there must be adequate resources and facilities in which to practice them. They also stated that clinical judgment skills were not innate and must be learned. They stated that clinical rotations would be greatly enhanced with the acquisition of clinical judgment skills.
Category: Patient First

All of the interviewees were emphatic about their beliefs that the use of clinical judgment skills was paramount in placing the good of the patient first. Interviewee Three (personal communication, October 31, 2013) stated, “...the first thing first, when I was at school, the clinical judgment...it’s all about how to care about, how to care your patient.” Each of the interviewees told stories from their personal experience that demonstrated their beliefs that the good of the patient was of greatest importance. Interviewee Eight, a Diploma Nurse who had relatively few years of nursing experience, gave the following personal example of using clinical judgment skills:

Some patients are dirty, they are not washed; some patients they don’t any food; others don’t have linen [undergarments]; their bed are not well straightened. But the moment you reach there and you see those patients, you can identify that these patients, they need one, two, three. Others are not ambulatory, they can’t do anything, they’re immobile. You can think of them, “What can I help this patient?” You can identify their need” (personal communication, October 28, 2013)

The culture of Tanzania is one in which males dominate (Isinika, 2011). In the medical and nursing fields, nurses are usually subservient to doctors who are most often male, although that trend is slowly changing. In such a culture, it is highly unusual for a female nurse to challenge a male doctor. However, the nurses’ belief that the patient’s welfare was of greatest importance as seen in Interviewee Ten’s statement, “No matter I quarrel with that doctor. My aim is to ensure that the patient is alive.” (personal communication,
October 29, 2013) In another situation, Interviewee Seven gave the following example of a situation in which the use of clinical judgment did not convince the doctor:

...one paediatric patient, it was almost below two months. When I passed there I found that patient developed difficulty breathing... and the temperature was very high...almost 40 degrees of centigrade. So I asked myself, how can I do that child. Can I give paracetamol? ...I decide to consult paediatrician... the doctor said, ‘No, don’t give.’ So I don’t give that paracetamol, and it was very bad to me. I didn’t let my clinical judgment. (personal communication, October 28, 2013)

The interviewee’s fear was that with such a high fever the patient would develop febrile seizures. Because the interviewee’s clinical judgment was not recognized in this scenario, the patient was allowed to suffer.

The interviewees were consistent in the view that it is important to use their clinical judgment skills when engaging the patient in order to enhance their presence with the patient. Individuality in Tanzanian culture is secondary to the sense of community (Hofstede, 2010). Nurses are expected to become involved with their patients and their patients’ families (Juntenen & Nikkonen, 2008). This involvement extends not just to the physical aspects of the patient, but also the psychological and sociological aspects of the patient. In order to do this, the nurse must be able to recognize complications in all three facets. Interviewee Eight explained this succinctly:

Therefore, the action of going and asking patients, ‘Do you have any problem? What can I help you? Why do you say, why do you seems like you are, you are not well? You are not in a good mood, what can I help you at this moment?’
Then you can provide something, you can do something, according to what you were told... (personal communication, October 28, 2013)

Several of the interviewees expressed thoughts that autonomy and cooperation with doctors were issues that increased their abilities to use their clinical judgment skills. Interviewee Four, a nurse/midwife who had extensive experience, gave the following illustration:

...I should use my clinical judgment so that I can identify the danger signs. One mother was admitted. She was gravida 9, para 0. So I’m the one who received the mother. Then I tried to talk with the mother, I know it’s a bad, she’s having a bad obstetric history. Then what I did, I communicate with the doctor... and he said, “If she’s eight-and-a-half months and the fetal heart rate has now improved, so you can put the mother in the ward until tomorrow.” [for a normal delivery] So I call the doctor again and I told him, “Remember, it’s a bad obstetric history, and she managed to reach eight-and-a-half months. So we need to do a Caesarean Section...” So the doctor agreed with me... (personal communication, October 28, 2013)

The same interviewee also stated that at times a lack of autonomy and cooperation were issues:

So I’m able to identify the needs of the patient, but sometimes we got an obstacle from the doctors. Yeah. Then later they say that, “Oh, you nurses were very slowly, you were not good in interpreting the condition patient.” (personal communication, October 28, 2013)
All of the interviewees expressed their thoughts about the importance of helping and caring for their patients through the use of clinical judgment skills. Interviewee Eight stated, “...through your clinical judgment, you can know, ‘What should I do now to help this patient?’” (personal communication, October 28, 2013) Interviewee Ten expressed great passion when relating a situation in which helping the patient was paramount:

...because it was an accident, the patient was not okay to be counseled... the coming day, the following day, I was on duty, morning shift. So I just receive my oral report, my written report, bed-to-bed report. But once I reach that patient, my heart was totally taken to stay with that patient, to talk with that patient, and to know how can we help that patient. (personal communication, October 29, 2013)

Communication with the patient and other healthcare workers was also stated as an essential component of the utilization of clinical judgment skills. Interviewee Two expressed thoughts concerning communication:

Process of communication takes a time. It is not something that takes in and so the person responds. It takes time. So you have to help the patient first and then make the communication, or you communicate while you’re still helping out.

Yeah. (personal communication, October 30, 2013)

Interviewee Five simply stated that, “Because we have to talk with patient so that we can know the problem of the patient. When you pass through without talking with the patient, we cannot know if patient is having a problem.” (personal communication, October 31, 2013)
Although none of the interviewees used the word advocate or advocacy, each of them gave examples of the use of these concepts from their careers as nurses. Along with advocacy, Interviewee Eight stated that one “can’t pass off responsibility” for the patient (personal communication, October 28, 2013) Interviewee Ten, a Diploma Nurse who had several years of experience as a nurse working in a hospital gave the following example of advocacy and taking responsibility:

As a nurse, I have to follow doctors’ pre-operative and post-operative orders. Unless I see that there is a mistake or wrong done, I have to act. But patient was complaining of pain. Pain and nasogastric tube is two things different. So I told doctor, “On your post-operative orders you did not document that the patient is supposed to be...to have nasogastric tube. Also, I call you yesterday about this patient, that the patient have severe pain, but you do not act. So today the patient condition is worsening. Let’s help the patient.” The doctor was, I can say, was mkali [very angry], because I saw that I’m just working up. (personal communication, October 29, 2013)

Interviewee Ten’s story is particularly interesting because as a female nurse, she had to show extraordinary tenacity in advocating so strongly for her patient to a male doctor. This incident played out over a three day period, anytime during which Interviewee Ten could have passed the responsibility for that patient to another nurse.

The interviewees unanimously stated that they used their clinical judgment skills in discovering the uniqueness of each patient or situation. Interviewee Eight gave an example of this from experiences gained in the OB/Gyn department:
Sometimes you may be given a report about the mother who is in labor... means the normal range. But the time maybe you are there maybe continuing with the other activities, you find the mother is screaming. Or you may pass there and find that the mother is like complaining pain. There the mother is not saying anything, but you think, “Why?” ... Others on the way they...cope with the pain, it’s quite different with the others. Every individual has...is unique. (personal communication, October 28, 2013)

**Category: Thinking More**

Although all of the interviewees were proficient in the use of the English language, two factors created interesting situations for the author. The first was the fact that English was the third language for the interviewees, and this language had only been learned in the second half of their primary education or the first years of secondary school. The other factor had to do with the style of English that they had learned which was British. These two factors combined to make sentence structure and word use by the interviewees subject to fascinating interpretation. Whereas in American nursing, single words would be used to describe clinical judgment skills in use, the interviewees tended to use phrases. For instance, the title of this category comes from a quote by Interviewee Eight when asked to describe how clinical judgment is used in a particular setting. “Therefore it’s your responsibility to think more, why... through thinking more, through clinical judgment, you find that you are going to help the patient.” (personal communication, October 28, 2013)

Another example of this use of language is seen in the response from Interviewee Six concerning thoughts about what clinical judgment is:
I can say, clinical judgment, I can say, maybe you are, like you are attending the patient. During attending the patient you can see something, maybe condition of the patient has changed, you have to add something else according to the situation. (personal communication, October 28, 2013)

Interviewee Six, as well as the majority of the interviewees, clearly understood that assessment and evaluation were both essential to the use of clinical judgment skills. Although the interviewees did not use the usual terms, “assessment” and “evaluation” as Western nurses most likely would, they used phrases that communicated the same concepts. Interviewee Four related the use of clinical judgment when identifying patients’ needs or danger signs, “And so in pregnant mothers I should use my clinical judgment so that I can identify the danger signs.” (personal communication, October 28, 2013)

Interviewee Five used the words “judge patient” in a response to a guided question that was directed to elicit a definition of clinical judgment skills.

Clinical judgment is the way you can judge the patient which is in front of you, what the problem of the patient is so that you can help and solve accordingly. Despite waiting the doctors, you can help and serve the patient accordingly. I mean without depending the doctor’s prescription. (personal communication, October 31, 2013)

The majority of the interviewees indicated that an integral part of clinical judgment included the independence to serve the patients’ needs. Since the concept of nursing autonomy is not the norm in their culture, this independence also indicated a level of risk taking that was also inherent to the use of clinical judgment skills in this setting.
(Haggstrom, Mbusa, & Wadensten, 2008). Interviewee One said much the same when defining clinical judgment skills:

The clinical judgment means when a nurse, when you are in the ward and you can judge where to start to work. Maybe you have many patients there. When you observe you can find where to start to work, who is need the first immediate care.

(personal communication, November 2, 2013)

This process of prioritization was very much evidenced in many of the interviewees’ responses. A few of the interviewees alluded to the use of intuition as part of clinical judgment skills. Interviewee Two expressed this best when explaining what clinical judgment skills were:

I’m in a situation whereby I’ve seen a patient, and the general appearance of the patient, and how the patient is at the bedside, or wherever I have seen, whether seated or whether standing or lying, I can do something, I can analyze the... if this patient needs my help or not. (personal communication, October 30, 2013.

The majority of the interviewees stated that clinical judgment skills were essential to nurses taking action to provide immediate care for their patients. Interviewee Ten summed this need as:

On my side, clinical judgment...clinical judgment is...helps nurses to act. To act, to give care to the patient without...without worrying about the doctor who is taking care of that patient by that time. Because the nurses, they have to act and put the act...their act into action. (personal communication, October 29, 2013)

Virtually all of the interviewees stated that the ability to “think more” came with experience. When asked how they saw clinical judgment skills being used within their
individual settings, the interviewees made some reference to younger nurses who were not able to successfully use clinical judgment skills. Interviewee One stated, “...the fresh nursing from the school, they have no enough clinical judgment to know what is emergency.” (personal communication, November 2, 2013) Interviewee Two stated, “But the newly employed, they have something called... they fear. Okay, ‘I don’t know what... if I do this, what will take place.’” (personal communication, October 30, 2013) Interviewee Nine gave the most succinct response:

They try, but it’s not really higher quality. Because of...especially the new ones who come. The newcomers, they are no, no, no much experience to the patient. And when we ask them, they say, “This is the first time to make this decision, we are new.” So sometimes it is not good. Yeah. (personal communication, November 4, 2013)

**Category: Attending the Patient**

Each of the interviewees identified personal and professional attributes of nurses who demonstrated clinical judgment skills by using stories from their own experiences as nurses. In particular, the interviewees stated that many of the junior nurses viewed nursing as a job and not as a profession.

**Personal characteristics.** The hospital in which the interviewees worked is a faith-based institution which begins each day with a short church service. Several of the interviewees expressed a deep commitment to God in their nursing. Interviewee Two spoke of God several times during the interview. “So when God brought a chance, I took 100 per cent advantage of it. Then I had to join nursing... By God’s grace...God’s grace, I was so... I was so much blessed in terms of researches.” (personal communication,
October 30, 2013) Interviewee Three responded, “You don’t have to do it the way that is not placing God first...” when asked how clinical judgment skills were used in that interviewee’s area of the hospital. (personal communication, October 31, 2013) The Christian characteristics of caring, compassionate, open service to patients were addressed by virtually all of the interviewees. Interviewee Three stated:

It depends with the character of a nurse. Sometimes there are those who are polite, they can just take things simple. There are those who are arrogant. So there are those who are applying clinical judgment accordingly, according to the way they trained at school, and according to the way they...they see other nurses are doing. (personal communication, October 31, 2013)

When describing a successful use of clinical judgment, Interviewee Four related the following:

...I know it’s a bad...she’s having a bad obstetric history. Then what I did, I communicate with the doctor, the gynecologist. And he said, ‘If she’s eight-and-a-half months and the fetal heart rate’s now improved, so you can put the mother in the ward until tomorrow.’ So I call the doctor again and I told him, “Remember, it’s a bad obstetric history and she managed to reach eight-and-a-half months. So we need to make a...I know the baby’s a precious baby. So we need to do a Caesarean Section, because it’s above eight months and then to save the baby. Because anything might happen.” ...he came, we review the mother together, and he said...the doctor said, “Prepare for emergency Caesarean Section...” And we managed to get a baby boy of 3.1kg. (personal communication, October 28, 2013)
The majority of the interviewees stated that nurses who had good clinical judgment skills considered nursing as a “calling” and not just a job. When asked to explain thoughts about clinical judgment skills were, Interviewee Nine described some new nurses:

And many of them, they are not...they are just coming, there is not a calling. Because nurses are a calling, but most of them they are not a calling; they come as a job. Because you can see when they handle the patient. Is it gently, is it...have they appreciated it like a human, maybe comfort them and so. Or maybe somebody tell her, “I feel pain,” and they don’t care. (personal communication, November 4, 2013)

Interviewee Two stated a personal philosophy concerning clinical judgment skills and nursing:

I don’t like...okay, me, I don’t much like the...what we call the Mama Nightingale kind of philosophy. We need to come out of that. Because the Mama Nightingale kind of philosophy is whereby we have to wait for only doctor to judge for ourselves. I think...there’s no thing...if we have to wait for that, then we don’t have to call nursing a profession. We only have to call it a calling. But for me, and what I understand, nursing is a profession. But this profession needs a calling. It’s both a profession and a calling. (personal communication, October 30, 2013)

**Professional characteristics.** Several of the interviewees were adamant in their beliefs that a major professional characteristic of a nurse who had clinical judgment skills was to be faithful. Interviewee Three, one of the less experienced interviewees stated:
...how I use clinical judgments in theatre. I think the first thing...the first thing for a nurse, you must be faithful and be open that anything you do, you do...anything you do as a nurse, you must be faithful first. If a patient comes, you do everything faithfully. (personal communication, October 31, 2013)

This concept extended to include the equal treatment of all patients and to advocate for one’s patients. Interviewee Two summed this concept up best, “I care for them. The way that...in case I fall sick, I would admire somebody to do. Do to others what you would like them do to you. That’s what impresses me most.” (personal communication, October 30, 2013)

Interviewee Ten spoke to the professional characteristics of identifying the needs of the patient, competency, organization, and helping the patient in response to a question of how the interviewee had learned about clinical judgment skills. During clinical rotations as a student, the interviewee was involved with a patient who had been in a vehicle accident.

So I was trying to counsel her about the total care of the...of the limbs... I told her the real situation. That if we deal with the fragmented bones, I say that we can rescue to limb, you will end up with septicemia, because the wound was not good at all. So I tried to counsel her for two days. The third day she agreed about amputation of the fragmented limb... So I just go back to my doctors...I gave them the outcome... So that patient was amputated... After one month she was discharged. (personal communication, October 29, 2013)

Interviewee Ten demonstrated a high degree of the professional characteristic of being responsible for the patient even in the face of the displeasure of a doctor.
I come across one patient with...it was post laparotomy, and he had a cyst on his liver... But the surgeon who did that operation just prescribed to that patient diclofenac injection [post-operative for pain]. I just take a phone and call the doctor, and I’m telling him of the progress of that patient. That patient is having severe pain... I phoned the doctor, but the doctor was saying that, “I know that guy is a young guy, he can tolerate that diclofenac until tomorrow. Do not give pethidine.” I contacted the other doctor who was on call by that day. And the doctor was also afraid to give the patient pethidine because of the reaction of the surgeon who did the operation. So patient is staying the whole night with pain...

Then I come early in morning... I just find nurses were running here and there because of that patient... They said, “No, the patient condition is worsening.” I just took my vital sign equipment, taking blood pressure is very low, pulse rate is very high, body temperature is abnormal... So I took the file, I ran to the chapel, I find the doctor... But he was somehow not ready to go with me and see the patient. But because I continue staying there without moving, he stand up and he following me. (personal communication, October 29, 2013)

Interviewee Ten took responsibility for the patient and advocated for that patient in the strongest possible way by publicly persuading the surgeon to attend to the patient.

Interviewee Ten’s actions also demonstrate professional characteristics that are of great consequence, that of bravery and leadership (Haggstrom et al., 2008). By standing quietly next to the surgeon at chapel, Interviewee Ten showed colleagues who were present in chapel, that nurses could prevail when advocating for their patients.

All of the interviewees indicated that the development of clinical judgment skills depended greatly upon the adequacy of resources and facilities. Even though Interviewee Eight was one of the youngest and least experienced of the interviewees, this interviewee gave the best description of this category:

Staff like us, we are to help those students, in one way or another. Whenever they fail to do something, we should not laugh, we should not leave them, we should not say, oh, so-and-so. But what we are supposed to do, it’s to provide help to them, to show them the direction, to show them the operation, that they should do what, what, what, so as to succeed. Through that we could find that this clinical judgment is promoted. (personal communication, October 28, 2013)

Two way process for school and staff. All of the interviewees stated the importance of a positive interaction between student nurses, inexperienced nurses, instructors, and mentors. In the Tanzanian nursing education scheme, a mentor is equivalent to a clinical instructor. Interviewee One, a nurse who had several years of experience, stated:

...the fresh nursing from the school, they have no enough clinical judgment to know...they should find a skilled clinical instructor in the clinical area, so that when the student come in the clinical area they will get the one who guided them in procedures, slowly, slowly, they will improve and can know how to judge. So she should find the experienced nurse who they will teach the student and guide when they come in a clinical area, guide them closely. Yeah, she might come
with a difficulty if she will not find a good instructor. (personal communication, November 2, 2013)

Interviewee Four, a nurse supervisor who had extensive experience also stated that there needed to be a connection between the inexperienced nurses or the student nurses and the experienced staff members and mentors. When asked what could be done to help with the new nurses or the student nurses, Interviewee Four replied:

...if it’s allowed she can give me a...some sessions for the students. I can teach them. And also, the only thing I can offer is to supervise the students in the wards when they are in the wards. I am able to do that, to supervise them, to instruct them, yeah, how to make a decision, how to deal with different conditions of the patients... If she can get a good supervision from the staffs who are there... the long-service staffs to help the juniors, it will be very simple. So I think it’s a... it’s a two-way process for the school and the staffs who are in the departments in order to implement the clinical judgment. (personal communication, October 28, 2013)

In a culture that puts the emphasis on the group rather than individuals, such as in Tanzania, putting oneself forward as a role model is somewhat presumptive (Hofstede, 2010). However, being a positive role model for student and junior nurses in the development of clinical judgment skills was a theme that was identified throughout several of the interviews. Interviewee Three explained this relationship in response to how other nurses were using clinical judgment skills:

Sometimes there are those who are polite, they can just take things simple. There are those who are arrogant. So there are those who are applying clinical judgment
accordingly, according to the way they trained at school, and according to the way
they...they see other nurses are doing. Like now, our in-charge, they are very
good. (personal communication, October 31, 2013)

Interviewee Ten, who quietly stood next to the surgeon in chapel until he acquiesced to
her request, demonstrated a powerful role model for all of the nurses. However, the act
of being a role model was not primary when this interviewee took those actions, but the
patient’s welfare was paramount.

Interviewee Two was quite passionate during the interview concerning the
importance of the tutors and mentors when assessing nursing students:

...and if you teach them the clinical judgment, they will use it there and then. But
there are some whose mind takes a long time to adjust to the knowledge given.
So what she should do is she should understand what kind of students she has.
Are they fast learning, are they more direct, or are they slow learners... Every
person needs a different approach. So once she understands that, it will help her
make a generation that will change the nursing. (personal communication,
October 30, 2013)

Interviewee Eight also stated that the assessment of teaching staff as well as the quality of
the facilities was equally important:

Ensure that they... you have good teachers for those students, you have enough
facilities for provision of enhancing learning there. When I’m talking about
facilities I mean books and classes, enough classes, models for teaching, et cetera.
Things like those. They can facilitate learning. Of which, through that good
learning, with good skills which are provided to those students, you will find that
at the end of the days, this... this clinical judgment is promoted. (personal communication, October 28, 2013)

The majority of the interviewees noted the importance of good supervision in the development of clinical judgment skills. Interviewee Five, the interviewee with the most number of years of experience related:

But if there is supervision, good supervision, I think they can help teachers to supervise the student...You are not going to sign the log book until you saw the student doing...maybe cannulation, maybe dressing, so that it can help that I’m going to do so you know, yes, she is perfect on doing dressing. So that you can sign. It will help. (personal communication, October 31, 2013)

Many of the interviewees expressed the importance of having skilled clinical instructors and experienced nursing tutors. Interviewee Four spoke of learning that an important aspect of being a nurse leader was “to be competent on all procedures and to lead others. And how to lead others is to identify the needs of the patient before others.” (personal communication, October 28, 2013). Interviewee One responded, “...they should find a skilled clinical instructor in the clinical area...” (personal communication, November 2, 2013) Interviewee Two, in response to obstacles to developing clinical judgment skills, suggested the following:

...she should take note of that, that though she may send some students in the ward, there are people there who may not like to assist. So she should be wise. And I think she should do this: before she sends the students to the wards, she should of and spend one hour and say, what kind of staff are there? Go to the
place, see the place, learn, are there equipments in that place? (personal communication, October 30, 2013)

Interviewee Five also stated that instructors should be current, “...that our teachers at the school would be well to be sure that they are also current on the floor.” (personal communication, October 31, 2013)

**Clinical applications combined with theory.** Mentoring in Tanzanian nursing education has two meanings (Ministry of Health and Social Welfare, 2008). The first meaning that is most familiar is that interaction between two people on a personal as well as professional level. Formal mentoring in the Tanzanian system refers to what is more commonly understood as clinical instruction in the clinical setting. Mentors are the equivalent of clinical instructors. Interviewee One expressed the importance of a good mentor during the interview;

> But if she has a good instructor and guide that student in the clinical area, not to abscond to the dormitories and what, they will improve. But if she will get...get them to lose...to go anywhere without any guide she will face difficulty with them...if she would guide them, she will get good products. (personal communication, November 2, 2013)

This concept of mentoring would be carried forward into the clinical setting, where students would be shown how to do particular procedures or to apply what they have learned in the classroom. Interviewee Seven explained this during the interview:

> ...when the students are taught about clinical judgment in theory, then maybe it is better to introduce in practical areas or clinical areas in the wards, and maybe Sister Shuma [Principal of a nursing school] to be together in the ward, especially
for the patient which very seriously ill. Mm-hmm, to go together and to
do...maybe to make assessment together with that students to the patient so
that...to make sure that that students will be able to make clinical judgment in
front of teachers. (personal communication, October 28, 2013)

Several of the interviewees recognized the importance of using different approaches in
the development of clinical judgment skills. Interviewee Ten stated that, “...in the
clinical areas...we are different, we are different ages, and we also differ in our...in
our...can I say, in our ranks.” (personal communication, October 29, 2013) This diversity
was also mentioned by Interviewee Seven when describing the age of young women
entering nursing schools at the age of eighteen and nineteen, as opposed to the mid-
twenties as was the case when Interviewee Seven entered school in 1990. Interviewee
Two stated:

   Every person needs a different approach. Though they are in the same class,
   there’s somebody you may teach today you’re teaching like this, ‘When you see
   this and this and this, do this and this and this. Or you need...this should come
   into your mind. (personal communication, October 30, 2013)

When asked about difficulties that might be faced in the new nursing school, Interviewee
Five noted that “I think that depending with the student personalities...and how student
appears and adapt that knowledge from their teachers,” (personal communication,
October 31, 2013) However, Interviewee Eight was most succinct in response to the
issue, “Every individual has...is unique.” (personal communication, October 28, 2013)
Summary of the Interviews

The majority of the interviewees knew the interviewer for several years. As a consequence, the majority of the interviewees were relaxed and very forthcoming during the interviews. However, Interviewee Six who had just two years of experience as a nurse showed great distress when asked to describe an experience when the use of clinical judgment was unsuccessful. Until that point in the interview, Interviewee Six’s non-verbal communication had been open and relaxed. This interviewee’s non-verbal behaviors quickly changed to crossed arms, tucked chin, and frown lines. Interviewee Six quickly recovered a relaxed attitude for the remainder of the interview after that question. Several of the nurses voiced frustration, even some anger, which concerned their interactions with doctors when they utilized clinical judgment skills. This frustration was observed as Interviewee Ten became agitated when relating the experience of passively confronting a doctor during morning chapel services. The interviewees were comfortable with the assurance that their responses in the interviews would remain confidential.

All of the interviewees actively participated in the interview process. In traditional Tanzanian society, female nurses are more often expected to be seen and not heard (Haggstrom et al., 2008). The interviewees gave their opinions unabashedly and often with great verve. Nine of the ten interviewees had several questions at the end of their interviews which may have demonstrated their interests in improving clinical judgment skills development in student nurses as well as in working nurses.
Final Assertion

All of the interviewees described phenomena from their own practices to illustrate both successful and unsuccessful uses of clinical judgment. From their experiences, the interviewees were able to identify obstacles to the application of their clinical judgment. In a culture where females are deemed subservient, the interviewees showed great strength and perseverance in the use of clinical judgment skills in their practices (Haggstrom et al., 2008; Isinika, 2011). The interviewees stated that experience in the clinical setting was of exceeding importance in the development of clinical judgment in student and junior nurses. The interviewees provided insights into the personal and professional characteristics necessary to fully develop and apply clinical judgment skills.
CHAPTER V
DISCUSSION AND RECOMMENDATIONS

As stated in Chapter I, there were two purposes for this research. The first purpose was to ascertain, through personal interviews, perceptions of a sample of Tanzanian nurses that regarded their educational experiences in the use of clinical judgment skills. The second purpose was to investigate these nurses’ perceptions of benefits and obstacles regarding appropriate approaches to the development of clinical judgment skills. The nurses chosen as interviewees worked in various areas of a 125 bed hospital in urban Arusha, Tanzania. All of the interviewees participated fully in the interviews, which was gratifying because in traditional Tanzanian society, female nurses are more often expected to be seen and not heard (Haggstrom et al., 2008). The interviewees gave their opinions unabashedly and often with great verve.

Discussion

The interviewees in this study had definite perceptions and opinions concerning clinical judgment skills development in their own nursing education as well as the nursing education that would be offered in a proposed new nursing school that would be affiliated with the institution in which they work. The research indicated that the nurses had a good grasp of clinical judgment and its importance to nursing practice. Benner et al. (2009) referred to clinical judgment skills as those attributes which nurses use both concretely and intuitively to understand their patients’ conditions. Interviewee Two’s definition of clinical judgment skills resonated with Benner et al. (2009) and was
representative of the majority of the interviewees’ understanding of clinical judgment skills:

“...okay, clinical judgment is what...I’m in a situation whereby I’ve seen a patient, and the general appearance of the patient, and how the patient is at the bedside, or wherever I have seen...I can do something...I can analyze... And see that this patient...if this patient needs my help or not. And which state he is. Is he happy or is he in pain, or is he...is he gasping or what. Such kind of analysis.” (personal communication, October 30, 2013)

Several of the interviewees joined two year Enrolled Nurse programs to begin their nursing education. These programs are somewhat similar to the two year Associate Degree in Nursing programs in the United States. However, the emphasis of Enrolled Nurse programs is split evenly between nursing and midwifery. This leaves little time for classroom nursing theory work and places more emphasis on practical training; this in turn does little to promote the development of clinical judgment skills. Interviewees who participated in Enrolled Nurse programs then joined advanced nursing programs, later in their careers, in order to become Registered Nurses, or Nursing Officers. The interviewee who was still an Enrolled Nurse had also completed post-graduate work in counseling and looked forward to a time when the hospital would provide those services. It was during these advanced programs that the interviewees perceived that they were exposed to the development of clinical judgment skills. The majority of the interviewees stated that it was during the third year of their nursing education that clinical judgment became a part of their curricula. They also stated that the best place to introduce clinical judgment skill was in the classroom, but the best place to develop those skills was in the
clinical setting. Several of the interviewees related personal stories of attaining experience and developing clinical judgment skills while being mentored in the clinical setting. One of the interviewees stated that great success was achieved during a clinical rotation in community nursing. This interviewee reflected about being in a remote village with a Catholic nun and was “taught how to deal with patients who were in need before they told you that they have a problem.” (personal communication, October 28, 2013)

The study also revealed the interviewees’ perceptions of the importance in obtaining experience to develop clinical judgment. Nine of the ten interviewees stated that new or junior nurses exhibited little or no clinical judgment. When asked possible reasons for this deficit, many of the interviewees stated that the junior nurses did not have enough experience in the hospital setting. This response is congruent with Ethridge’s (2007) findings that experience was the most important aspect of developing clinical judgment skills.

This study also found that competent mentoring of student nurses, as well as junior nurses, was of paramount importance to these interviewees. All of the interviewees stated that experienced nurses needed to become involved in any new clinical experiences that included student nurses. This correlates closely with White’s (2003) findings that student nurses believed their relationships with other nurses were most important in developing clinical decision making skills. Further, the present study found that there was a need for tutors and mentors not only to be knowledgeable and experienced, but to also be current and have recent experience in the area in which they
would be instructing or mentoring. This finding is supported by the findings in Forrest et al. (1996), which stated that nursing educators should also be practicing clinical nurses.

Several of the interviewees also stated the importance of maintaining adequate and proper resources and facilities to develop clinical judgment skills in student and junior nurses. This emphasis on resources and facilities might be considered a somewhat facile conclusion in the study. However, as noted earlier, when nursing textbooks that were available were as much as forty years old and visual aids were meager to nonexistent, the importance of having appropriate resources and facilities becomes understandable. Resources should include a student library with current nursing reference works, the internet, and up to date textbooks. Facilities should include a well-equipped skills laboratory; computer access; as well as ventilated and illuminated classrooms.

The study also found that the majority of the interviewees were interested in filling positions as either mentors or as instructors. Interviewee Four, a senior nurse who had several years of experience exhibited great passion when asked about working with junior nurses:

Though, I’m very happy, because those are... from school, right from school, they do care for the patients. They have an... at least they have an insight... the only thing I can offer is to supervise the students in the wards when they are in the wards. (personal communication, October 28, 2013)

Several of the interviewees expressed great interest in mentoring or tutoring other nurses and nursing students by their non-verbal communications such as facial expressions, sitting forward in their seats, and extravagant hand gestures. Surprisingly, some of the interviewees stated that one of the obstacles that the nursing school might confront in the
development of clinical judgment skills was staff who either would not want to participate or who would set bad examples in their work habits.

The richest source of data came from the interviewees’ personal stories of using their own clinical judgment skill both successfully and unsuccessfully in patient situations. Several of the interviewees related their experiences of using their clinical judgment skills successfully, even when confronted with opposition from senior members of the hospital staff, particularly doctors. This study showed that the acceptance of nurses’ clinical judgment by members of the medical staff was still in transition. However, the data from the study also showed a willingness by nurses to utilize their clinical judgment in advocating for better patient outcomes. The passive confrontation of a doctor by Interviewee Ten is a shining example of this advocacy, as well as an example of the diplomacy that is needed in this setting.

When they related stories that concerned unsuccessful use of clinical judgment, many of the interviewees were very circumspect. During analysis, the interviewer kept in mind an interesting aspect of the Tanzanian culture. In several of the village dialects in Tanzania, as well as in Kiswahili, there is no way for a speaker to accept responsibility for an action (Fr. P. Patton, personal communication, December 2012). For instance, if a Kiswahili speaker accidently drops a cup they would say, “The cup fell,” not, “I dropped the cup,” placing the emphasis of the action on the cup and not themselves. (Fr. P. Patton, personal communication, December 2012) With this in mind, the study was valuable in detecting ways in which the interviewees perceived that they had not properly used their clinical judgment skills. Several of the interviewees became somewhat emotional as they related experiences in which they were unable to facilitate a good patient outcome. One
of the interviewees was unable to answer the question and almost wept from the stress of answering this question.

When queried about obstacles in the development of clinical judgment skills, several of the interviewees mentioned the age of nursing students upon entry into nursing school and upon entering the nursing profession. In the past decade children have been able to enter primary school at much earlier ages. They were able to advance from primary to secondary school more quickly. Plus, with the advent of government student loans and support from faith-based organizations, young women, in particular, were able to go directly into post-secondary schools from secondary schools. Cumulatively, this means that nurses were graduating from nursing schools at a much younger age and had far less life experiences. Several of the interviewees did not graduate from nursing school until their mid to late twenties when compared to nurses who had recently graduated from Enrolled Nurse programs at age nineteen. The interviewees believed that this lack of age and life experiences were serious obstacles to the development of clinical judgment skills in students and in junior nurses. Norman et al. (2007) and Luker and Kenrick (1992) support this premise that clinical judgment is dependent on a nurse’s experiences.

The interviewees were unanimous in their assertions that the use of clinical judgment skills was extremely important in providing excellent nursing care for their patients. This assertion coincides with White (2003) who found that the professional nurse would be little more than a technically trained staff member if the nurse did not utilize clinical judgment skills. Each of the interviewees related stories of successful use of clinical judgment skills. Without self-aggrandizement, these stories often ended with
the patients’ lives being saved due to prompt application of the nurses’ clinical judgment often while confronting a superior. In several instances, the interviewees reported that an important obstacle to the development and use of clinical judgment skills were the attitudes of some of the medical staff. This interplay between the nursing staff and medical staff is much the same as that described by Stein (as cited in Benner, 2009) as the doctor-nurse game enacted in order to prevent open conflict in all circumstances.

**Implications for Nursing Practice**

Although there has been research completed that has addressed clinical judgment in other developing countries, there does not seem to be any research of this nature that has been conducted in Tanzania. Tanzanian culture has several interesting aspects that are unique; hence the importance of this research dealing with the perceptions of Tanzanian nurses. At the time of this study, nursing in Tanzania was transitioning from a somewhat antiquated bio-medical model to a much more patient-centered, bio-psycho-social, nursing profession (M. J. Jacobson, personal communication, March 2005). This study revealed that many of the interviewees considered the profession of nursing as a “calling” and not just a job. Through the experiences and perceptions of the interviewees in this study it was noted that these practicing nurses were knowledgeable concerning clinical judgment and understood the importance of using clinical judgment to support their patients. Patient outcomes were cited as being among the positive rewards attendant to the use of sound clinical judgment.

This study also helped the researcher to understand the interviewees’ willingness to promote the development of clinical judgment skills in their colleagues. It also revealed that one of the obstacles alluded to by several of interviewees dealt with nurses
in the clinical setting being unable or unwilling to properly mentor student nurses. By bringing this obstacle to the forefront, this study can be used to encourage all nurses to participate in the development of clinical judgment skills in student nurses as well as practicing nurses.

Through the recollections of the interviewees, this study found positive aspects of the interviewees’ educational experiences that enhanced the development of clinical judgment skills. These aspects included such things as a tutor’s attitude toward students; the mentoring that occurred in a hospital setting; and the camaraderie of the students.

The study also revealed that the interviewees believe that the best place to develop clinical judgment skills was in the clinical setting; whether in a hospital or in a village. The study gave insight into the interviewees’ perceptions that hands-on experience was of paramount importance in the development of confidence in using clinical judgment. The interviewees’ insistence that the role of the mentor in the clinical setting was key to the increased use of clinical judgment skills added veracity to the concept; this was be true for both nurse students and junior nurses. The data from the interviews also revealed a willingness on the part of the interviewees to become mentors. All of these positive factors can now be included in both in-hospital and nursing school programming that deal with the development of clinical judgment.

This study revealed an obstacle that will need to be dealt with if the development of clinical judgment in either nurse students or working nurses is to move forward. Through their personal stories of using their clinical judgment, several of the interviewees told of resistance from medical staff. Although the perception of the interviewees was that this obstacle was being alleviated to some extent, it is still
something that must be addressed in relationship to the development and use of clinical judgment skills by student and junior nurses.

This study revealed a deep concern on the part of the interviewees concerning the age and maturity of young women who were entering nursing schools and the nursing profession. Due to factors that are beyond the control of the nursing profession, there is little that can be done to affect this problem. However, since there is recognition of the problem, nursing education programs can be designed to inject more life experience training or education as well as clinical experience in their curricula.

Although this study did not reveal any direct evidence of the relevance of culturally appropriate approaches to the development of clinical judgment skills, the data gave some understanding of obstacles that might be in place related to Tanzanian culture. Self-reflection has been found to be an important tool in the development of clinical judgment skills (Murphy 2004). The present research is very useful in this instance since it emphasized the importance of understanding the way in which a Tanzanian nurse might understand and communicate self-reflection. The interview process also revealed that the interviewees’ friable emotions need to be recognized when designing programs for the development of clinical judgment.

Recommendations for Further Study

This study adds to the recent body of nursing knowledge that concerns the development of clinical judgment skills, particularly in a developing country. Although the interviewees in this research were very forthcoming in their responses, more research is needed to ascertain detailed perceptions of nurses concerning the development of clinical judgment skills by nursing students and practicing nurses.
Although well within the parameters set for proper qualitative research, the sample (n=10) was small. The sample was also chosen from the nursing population of a hospital that was not representative of the majority of hospitals in its geographic area. Attention was given to choosing participants from each of the five wards of the hospital; however attention was not given to the participants’ years of experience. Since outcomes from a qualitative study are not easily generalized, a quantitative study could be designed to measure the participants’ clinical judgment skills. A better sampling might include criteria such as sex, nationality, length of experience, age, or nursing specialty. Themes from such a sampling could provide information that could be used to adjust in-hospital education programs as well as nursing school curricula. In addition, research could be conducted in a more traditional hospital setting to compare findings between the two sample populations.

This study brought forth possibilities regarding the use of comparative research into the acquisition of clinical judgment skills experiences either during clinical rotations as students and through nursing practice. As of 2013, the Tanzania Nurses and Midwives Council, the governing body for Tanzanian nurses, has mandated the transition from demonstration labs to skills labs in all nursing schools. Qualitative research could be designed to ascertain the perceived effectiveness of the transition from both the standpoint of the students and from the view of tutors who had previously used the demonstration lab model. Such a study could aid in the refinement of the use of skills labs; the equipage of the labs; and the design of the labs. Although Benner et al. (2009) stated that simulation is a vast improvement over simple skills labs and would make an
interesting study, simulation mannequins and maintenance expenses were beyond the budgets of any nursing school in Tanzania at the time that the study was conducted.

The issue of the relationship between nurses and doctors has been the impetus for numerous studies. In this study, many of the interviewees complained of a lack of collegiality between themselves and doctors. A phenomenological qualitative study could be designed that would concentrate solely upon this issue. A wider sampling of nurses could be chosen and in order to make data collection and interpretation less cumbersome, questions could be limited. It would be instructive to also elicit responses from doctors. Such a study could be used to lessen tensions and increase understanding between the two professions and thus encourage the development of clinical judgment skills in nurses.

This study revealed perceptions of the interviewees that were related to their concerns about the age and experience of new nursing students and junior nurses who were entering the profession of nursing. The traditional nursing school at the time of the study was a residential school in which almost every aspect of the students’ lives was dictated by the school administration. Dormitories were reminiscent of military barracks in that a matron watched over the students, woke them in the morning, inspected bed making, sent the students to breakfast, supervised study time, and turned off the lights in the evening. Recreational activities were even supervised. Students had little decision making about their lives. By the time a young woman had graduated from nursing school, she had never shopped for groceries, never rented an apartment, or never cooked a meal by herself. The proposed new nursing school was considering the inclusion of seminars in life skills which would allow the students to think, perhaps critically, and
make decisions for themselves. Initially attendance at the seminars would be voluntary. A study could be designed to compare clinical judgment skills development between a group who attended the seminars and a group that does not attend the seminars. If the results of the study are positive in favor of the seminars, they could be made mandatory and the results of the study could be shared with other nursing schools as well as the Tanzania Nurses and Midwives Council.

**Summary**

There were two purposes for this study; the first was the examination of the perceptions of nurses regarding their educational experiences in the development of clinical judgment skills. The second purpose was to ascertain the perceived benefits and obstacles in the use of clinical judgment skills in nurses who worked in a 125 bed urban hospital in Arusha, Tanzania. The main thrust of both of these goals was to better understand how positive change could be affected in the development of clinical judgment skills in nursing school curricula and in-hospital nursing education programs. All of the interviewees strongly advocated that the development and use of clinical judgment was vital to positive patient outcomes. Many of the interviewees also believed that when they utilized these skills, their clinical judgment was not respected, or that they had to place themselves in extremely uncomfortable positions in order to best advocate for their patients.

The interviewees were adamant in their statements that the inclusion of clinical judgment skills in the clinical setting by well qualified mentors was tantamount to the success of creating the beginnings of a nurse who could utilize clinical judgment. Participation in this study encouraged several of the interviewees to consider becoming
mentors for nursing students who would be present in their wards. The data from this study also showed the importance of having adequate current resources and facilities. The data suggests that plans for nursing school libraries, as well as the hospital libraries, must include current nursing reference works. Nursing school skills labs should be fully stocked and the equipment should reflect settings in hospitals in which students will spend clinical rotations.

The developing world is a well spring of potential research opportunities. Tanzanian nursing, because it is in the beginnings of the transition into a profession, represents a cornucopia of possible research projects. This study of the development of clinical judgment skills in Tanzanian nurses could be expanded in several different ways. The effects of the primary and secondary education systems on post-secondary education and the development of clinical judgment could be studied quantitatively and qualitatively. A comparative study of nurses from different geographical areas would be interesting as well as instructive. The possibilities are endless. Any research that is conducted on the topic of clinical judgment in Tanzanian nurses can improve the public’s perceptions of nursing, which in turn could improve recruitment of women and men into the profession of nursing.

With nurse staffing running as low as fourteen percent in many Tanzanian hospitals, the nursing profession is in dire need of more nursing candidates (Manzi et al., 2012). Increasing the complexity of the problems facing the nursing profession in Tanzania is the influx of medical missionaries, particularly surgeons from the United States and Europe. These surgeons bring high expectations that Tanzanian nurses utilize well-developed clinical judgment. Those expectations can only be met through the inclusion of clinical judgment skills development within nursing school curricula as well
as in-hospital continuing education programs. The interviewees in this study have experienced these expectations first hand in their practices. It is evident from the data gathered in this study, that the inclusion of clinical judgment skills development in nursing schools’ curricula is of vital importance.

Benner et al. (2009) established the importance of clinical judgment in the development of expert nurses. The researcher anticipated that interviewees would provide answers that would be specific to help Tanzanian nursing students and nurses develop clinical judgment. However, the researcher serendipitously found that the suggestions given by the Tanzanian nurses during the interviews regarding the development of clinical judgment in nursing students and nurses included the provision of adequate library resources; mentors and tutors who want to teach; adequate clinical experience and patient exposure; appropriate skills labs; and computer access were suggestions that could be applied universally to all nursing students and nurses in the development of clinical judgment, regardless of nationality.

As the medical side of the health care equation in Tanzania becomes more intricate, the nursing side of the equation that promotes positive patient outcomes must keep pace with the medical side of the equation. The prevalent model of Tanzanian nurses as handmaidens to doctors is giving way, as evidenced by the data gathered for this study, and must continue to be replaced by professional nurses highly skilled and confident in the use of clinical judgment.
Appendix A

Letter of Introduction to Potential Participants
Dear Sister,

I am asking for your help in gathering information about clinical judgment skills that you might have learned during your nursing education and that you use at Arusha Lutheran Medical Centre. Clinical judgment skills are skills that nurses use to know about their patients’ needs and what nursing procedures to use or to change so that they can help their patients.

When you agree to help, we would schedule a time, during working hours, for me to ask you some questions about your nursing education and career. Your answers would be like stories that you tell about your life experiences as a nursing student and as a nurse. I would record your answers with a digital recorder and then have the recordings typed onto paper. All of your answers would be very private and no one, other than the transcriptionist, my professor, and I will see your answers. The transcriptionist is a professional lady from the International Criminal Tribunal for Rwanda. She understands the importance of the privacy of your answers.

The reason for this study is to help in developing coursework for the new college of nursing that we are starting. I am also using this information to complete a Masters in Nursing Education at the University of Mary in Bismarck, North Dakota.

Thank you, so much, for considering helping me with this important study.

Blessings,

R. Kent Thompson, BS, RN
MSN Ed Candidate
University of Mary
Appendix B

Letter of Introduction to Potential Participants (Kiswahili version)
Ndugu,

Napenda kuomba msaada wako katika kukusanya taarifa kuhusu ujuzi wa huduma za kitabibu na ujuzi wa uuguzi na masomo yako ya uuguzi na ujuzi za huduma za kitabibu ambazo uliupata wakati wa masomo yako ya uuguzi na masomo yako ya uuguzi na Arusha Lutheran Medical Centre. Ujuzi wa huduma za kitabibu ni ujuzi ambao wauguzi wanatumpa kujua mahitaji wa wagonjwa na wanaowahudumia na taratibu zipo za kuuguzi wanazoweza kutumia au kubadili ili kuwezasaidia wagonjwa wao/wanaowahudumia. Ujuzi wa huduma za kitabibu ni ujuzi ambao wauguzi wanatumia kujua mahitaji wa wagonjwa na wagonjwa wanaowahudumia na taratibu zipo za kuuguzi wanazoweza kutumia au kubadili ili kuwezasaidia wagonjwa wao/wanaowahudumia. Ujuzi wa huduma za kitabibu ni ujuzi ambao wauguzi wanatumia kujua mahitaji wa wagonjwa na wagonjwa wanaowahudumia na taratibu zipo za kuuguzi wanazoweza kutumia au kubadili ili kuwezasaidia wagonjwa wao/wanaowahudumia.


Asante sana kwa kukubali kwako kunisaidia katika utafiti huu muhimu.

Baraka

R. Kent Thompson, BS, RN
Mwanafunzi wa Elimu ya Uuguzi ngazi ya Shahada ya Uzamili
Chuo Kikuu Mary
Appendix C

University of Mary IRB Approval Form
October 7, 2013

Dr. Julie Klein
University of Mary
School of Health Sciences

RE: IRB Proposal 417091916, Clinical judgment in Tanzanian nurse education

Dear Investigator,

The University of Mary Institutional Review Board has reviewed and approved the above referenced study. This approval is valid for 12 months from today’s date.

Conditions of Approval: There are six (6) conditions attached to all approval letters. All six conditions must be met, or the IRB’s approval may be suspended.

1. No subjects may be involved in any study procedure prior to the IRB approval date or after the expiration date. (Principal Investigators and Sponsors are responsible for initiating Continuing Review proceedings.)
2. All unanticipated or serious adverse events must be reported to the IRB.
3. All protocol modifications must be IRB approved prior to implementation, unless they are intended to reduce risk. This includes any change of investigator or site address.
4. All protocol deviations must be reported to the IRB within 14 calendar days.
5. All recruitment materials and methods must be approved by the IRB prior to being used.
6. The IRB must be notified upon completion of the project.

Principal investigators are responsible for making sure that studies are conducted according to the protocol and for all actions of the staff and sub-investigators with regard to the protocol. As a principal investigator, you may have multiple and possibly conflicting responsibilities to the IRB, the research subjects, and any sponsor. If you have any questions or concerns about this approval, please contact the Assistant Vice-President for Academic Affairs, the IRB Chairperson, in the Office of Academic Affairs.

Sincerely,

Kim Long, PhD
Chair, Institutional Review Board
Assistant Vice President for Academic Affairs
University of Mary
7500 University Drive
Bismarck, ND 58504
T: 701.355.8021
F: 701.255.7687
Appendix D

Arusha Lutheran Medical Centre IRB Approval
22 October 2013

R. Kent Thompson
P.O. Box 417
Howard, S.D. 57349

Re: IRB Approval of your Thesis Research.

Dear Mr. Thompson,

It is our pleasure to inform you that your proposed thesis study at ALMC has been reviewed by the Hospital Internal Review Board and the IRB has approved this application.

You are expected to fulfil all of the ethical guidelines as described in your proposal and to provide this board with a copy of your final thesis.

We wish you well in this important research study.

Regards,

Prof M. Jacobson
Executive Director
Chair of ALMC IRB
Appendix E

Informed Consent Form

For Proposed Research:

Clinical Judgment in Tanzanian Nurse Education
Informed Consent Form

For Proposed Research:

Clinical Judgment in Tanzanian Nurse Education

Explanation:

This information is being given to you so that you can decide if you will volunteer to help with a research project that will be completed here at Arusha Lutheran Medical Centre (Hospital).

The reason this research is being done is so that we can learn more about nurses’ thoughts, feelings, and experiences concerning clinical judgment skills. Information that is learned from this study will be used to help nursing’s knowledge base to assist in developing curricula involving clinical judgment skills for nursing schools.

Risk and Benefits:

The information to be studied will be gathered from nurses chosen from each department in the Hospital. You may choose not to participate in this study without any penalty to your employment. Each nurse chosen will be interviewed just once for about 60 minutes. The interview will be recorded so that it can later be transcribed and then analyzed. There are minimal risks to you if you help with this study. You may experience some discomfort when discussing your educational and/or your work experiences. Since the interviews will be done during your working hours, you will not suffer any loss of salary. Your duties will be taken care of by a nurse who will be put on the schedule just for this purpose. If at any time you do not want to continue to help with the study, you can tell Brother Kent and you can stop participating in the study with no penalties to your employment.

New Information:

Information gathered in this study can be used to help develop nursing curricula as well as continuing education sessions within hospital to increase the use of clinical judgment skills.

Benefits to be Expected:

It is hoped that with increased knowledge of clinical judgment skills, nurses will be able to better serve patients. If we are successful, we will all be better nurses.

Confidentiality:
Those nurses who are willing to participate will be assigned a special code number. That code number will be used on all documents instead of a name. The key to the code numbers will be kept by Brother Kent in his locked file cabinet in his office. The transcribed interviews will be kept in Brother Kent’s locked desk in the Matron’s office when he is not working with the interviews. Once all of the interviews are completed and transcribed, Brother Kent and his thesis chair will analyze the interviews. When the analysis of the interviews is finished and the final thesis is written, all of the information gathered in the interviews will be kept for three years and then completely destroyed.

Your name will not be used and individual information will not be shared with your employer. Data will only be shared in aggregate so your employment status will not be affected. Very strict confidentiality will be maintained by securing names, code numbers and interview transcripts in separate secure locations in Brother Kent’s office. No one other than Brother Kent will know, so there will be no problems created if you want to stop the interview.

**Contact Information:**

If you do want to stop helping, you can call or SMS Brother Kent at +255783894910. You may also contact Brother Kent through email at rkthompson1@umary.edu. If you wish, you can also let Matron Christine know. You can also contact Brother Kent’s thesis Chair, Dr. Julie Klein at the University of Mary, +1-701-355-8106, or through her email at jeklein@umary.edu.

**Freedom of Consent and Approval:**

Your help with this research is voluntary and you can decide not to help or to quit at any time without any penalties to your employment. If you do decide to stop helping with the research, you can stop at any time without any problems in the Hospital.

**Voluntary Participation/Medical Treatment:**

My signature below acknowledges my voluntary participation in this research project. Such participation does not release the researcher, the University of Mary, or other agencies from their professional and ethical responsibilities to me. Potential risks from participation in this research project have been disclosed to me. I acknowledge that unforeseeable and/or unknown risks or discomforts may occur. In the event that medical treatment occurs as a result of normal participation in this research project, the University of Mary, or other agencies will not be responsible for my medical costs or other damages incurred in the absence of fault on their behalf.

This research will be completed by the end of the year 2013 and I will be happy to share the results with you when I return to Arusha in January 2014.
I agree to participate in this research study and have my interview digitally recorded

________________________________________  _______________________________
Signature of Participant                     Date

________________________________________  _______________________________
Signature of Researcher                      Date
Appendix F

Informed Consent Form

For Proposed Research:

Clinical Judgment in Tanzanian Nurse Education (Kiswahili version)
Informed Consent Form

For Proposed Research:

Clinical Judgment in Tanzanian Nurse Education (Kiswahili version)

Fomu ya Ridhaa

Kwa matumizi ya Utafiti

Mtazamo wa Kitabibu katika Elimua ya Uuguzi Tanzania

Maelezo:
Taarifa hii unapewa ili uweze kuamua kama utajitolea kushiriki kusaidia kwenye mradi wa utafiti huu ambao utafanyakia hapa Arusha Lutheran Medical Centre (hospitali)

Changamoto and Faida:
Taarifa zitakazotumika kwenye utafiti zitakusanywa kutoka kwa wauguzi watakaochaguliwa kutoka kwenye kila idara ndani ya hospitali. Unaweza kuchagua kutoa unapuwezi kwenye kila mtu ambacho kuchaguliwa na hospitali na unaweza kuchagua kutoa tofauti za kutoa hifadhi ya ujuzi wa kitabibu. Kila muuguzi atakayechaguliwa afya kwenye hospitali unaweza kufanya kutoa chache kwenye hospitali na unaweza kufanya kutoa chache kwenye mshahara. Majukumu yako yatachukuliwa na muuguzi ambaye atawekwa kuhusu kwenye matumizi ya utafiti bila kusaidia kwenye utafiti na watafuta kutoa chache kwenye hospitali na kufanya kutoa chache kwenye mshahara.

Taarifa Mpya:
Taarifa zitakazotumika kwenye utafiti zitakakusanywa kutoka kwa wauguzi watakaochaguliwa kutoka kwenye kila idara ndani ya hospitali. Taarifa hii unapewa ili uweze kuamua kama utajitolea kushiriki kusaidia kwenye mradi wa utafiti huu ambao utafanyakia hapa Arusha Lutheran Medical Centre (hospitali) na unaweza kuchagua kutoa unapuwezi kwenye kila mtu ambacho kuchaguliwa na hospitali na unaweza kuchagua kutoa tofauti za kutoa hifadhi ya ujuzi wa kitabibu. Kila muuguzi atakayechaguliwa afya kwenye hospitali unaweza kufanya kutoa chache kwenye hospitali na unaweza kufanya kutoa chache kwenye mshahara. Majukumu yako yatachukuliwa na muuguzi ambaye atawekwa kuhusu kwenye matumizi ya utafiti bila kusaidia kwenye utafiti na watafuta kutoa chache kwenye hospitali na kufanya kutoa chache kwenye mshahara.

Faida zitarawajiwazo:
Inatumainiwa kwamba kutokana na kuongezeka kwa ujuzi wa kitabibu, wauguzi wanatakwa na uwezo wa kuhudumia wagonjwa vizuri. Ikiwa tutafanikiwa, wote tutakuwa wauguzi wazuri.
Usiri:

Taarifa za Mawasiliano:
Kama ukita ka kuacha kusaidia, unaweza kumpigia simu au kutuma ujumbe mfupi wa maandishi Kaka Kent namba +255783894910. Unaweza pia kuwasiliana na Ndugu Kent kupitia anuani yake ya barua pepe rkthompson1@umary.edu. Kama utapenda, unaweza amfuchia pia na Matron, Christine. Unaweza kuwasiliana na mwenyekiti wa Ndugu Kent, Dkt. Julie Klein wa Chuo Kikuu Mary, namba +1-701-355-8106, au kupitia anuani yake ya barua pepe jeklein@umary.edu.

Uhuru wa kukubali na kupitisha:
Msaada wako katika utafiti huu ni wa kujitolea na unaweza kuwaamua kutokusaidia au kughairi wakati wowote bila faini yoyote kwenye ajira yako. Kama ukiamua kuacha kusaidia na utafiti, unaweza kuamua kutokuhusika kwa madhara yeyote hospitalini.

Kujitolea kushiriki/Tiba:
Sahihi yangu hapa chini inatambulisha kujitolea kwangu kushiriki katika utafiti huu. Ushiriki huu hauwaondoe mtafiti, Chuo Kikuu Mary au taasisi yeyote ile kwenye maadili yao ya kitaaluma na majukumu kwangu. Changamoto zinatotarajiwa kwenye ushiriki wangu katika utafiti huu zimewekwa wazi kwangu. Ninatambua kwamba changamoto zisizotarajiwa na/a zisizojujulika zinaweza kujitolea kwa kutokuda au taasisi zingine hazitahusika kwa gharana za huduma za matibabu yangu au uharibifu wowote utakaojitokeza kwa niaba yao
Utafiti huu utamalizika mwisho wa mwaka 2013 na nitafurahi kukushirikishwa matokeo yake nikirudi Arusha mwezi Januari 2014.
__________________________ Nakubali kushiriki katika utafiti huu na kurekodiwa mazungumzo yangu kidijitali.
Saini ya Mshiriki

Tarehe

Saini ya Mtafiti

Tarehe
Appendix G

Interview Guide
Interview Guide

1. Tell me about your life, from your birth to today. (As extensive as this may sound, it is something that nurse students are trained to do for job interviews. Since this is a familiar question it may help make this interview process less daunting. It will also yield tribal affiliation, age, marital status, as well as educational background.)
   a. Are you a Certificate, Diploma or Enrolled Nurse?
   b. In what area of the hospital do you work?

2. Please tell me what you think Clinical Judgment means.

3. Tell me your story about how you learned about using clinical judgment during your time at (name of nursing school).
   a. From whom did you learn this?
   b. In what year were you at (name school) when you learned this?

4. Tell me about how you use clinical judgment skills in the (hospital ward).

5. Tell me your best story about using clinical judgment skills in the (hospital ward).

6. Tell me your story about unsuccessfully using clinical judgment skills.

7. Generally, how do you see clinical judgment skills being used in the hospital?

8. If you were going to help Sister Shuma, the Principal of the new Nursing School, to develop clinical judgment skills in the nursing students, what would you do?
   a. What difficulties do you see in doing this?

9. Do you have any question you would like to ask me?
Appendix H

Pre-Interview Checklist
Pre-Interview Checklist

1. The reason for the interview.
2. Explanation of Clinical Judgment
3. Structure of the interview.
4. Interview length
5. Confidentiality reassurance
6. Permission to use tape recorder along with an explanation of transcription
7. Give permission for interviewee to ask questions
8. Explain that interviewee does not need to answer all questions

(Adapted from Whiting, 2008)
References


