Original Article

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Balancing power: A grounded theory study on partnership of academic service institutes

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Abstract

Introduction: Governments and professional organizations have called for new partnerships between health care providers and academics to improve clinical education for the benefit of both students and patients. To develop a substantive grounded theory on the process of forming academic-service partnerships in implementing clinical education, from the perspective of academic and clinical nursing staff members and managers working in Iranian settings.

Methods: The participants included 15 hospital nurses, nurse managers, nurse educators, and educational managers from two central universities and clinical settings from 2009 to 2012. Data were collected through 30 in-depth, semi-structure interviews with the individual participants and then analyzed using the methodology of Strauss and Corbin's grounded theory.

Results: Utilizing "balancing power" as the core variable enabled us to integrate the concepts concerning the partnership processes between clinical and educational institutes. Three distinct and significant categories emerged to explain the process of partnership: 1) divergence, 2) conflict between educational and caring functions, and 3) creation of balance between educational and caring functions.

Conclusions: In implementing clinical education, partnerships have been formed within a challenging context in Iran. Conflict between clinical and educational functions was the main concern of both sides of the partnership in forming a collaborative relationship, with our findings emphasizing the importance of nursing educators' role in the establishment of partnership programs.

Keywords: Education; Nursing student, Power; Partnership practice

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Introduction

A review of nursing education history shows that the movement of nursing to high academic levels increased the aforementioned theory-practice gap in nursing education (1, 2). Early academic leaders believed that better instruction for nursing students would result in better nursing care (3). Clinical education is the heart of nursing education and the responsibility of everyone involved in delivering health care (3, 4).

Nursing practice education involves academic and health care organizations and is thus influenced by both contexts (5). Academic-service partnerships are often touted as a solution to problems, such as nurse shortages, lack of clinically competent academics, and

insufficient clinical educational environments. In addition, partnerships between academic and service institutes in nursing can help to enhance nursing research and facilitate the development of evidence-based nursing (6). By combining the individual perspectives, resources, knowledge, and skills of the partners, the group creates something new and valuable together – a whole that is greater than the sum of its individual parts. In other words, partnerships lead to creation of a shared school of critical thought regarding nursing education and nursing care (7-9). Furthermore, partnerships may provide an opportunity for staff development and in-service training for clinical nursing employees through collaborative activities (6, 10, 11).

Academic-service partnership models have appeared in literature since the 1900s. A large number of articles have reported how such joint ventures between educations and clinical bodies have taken shape and been implemented (8). Together with this interest and activity, however, academic-service partnerships have also produced a good deal of frustration. Since partnerships require connections, procedures, and structures that are quite different from the ways many people and organizations have worked in the past, building effective partnerships is time consuming, resource intensive, and very difficult (7). "Estimates suggest that up to half of the partnerships that form do not survive their first year; of those that do, many falter in the development of plans or in the implementation of interventions" (7, 8, 12). There is also a concern that a substantial proportion of "forced" collaborations—those required by funders—may be partnerships only on paper (7).

Governments and professional organizations have called for new partnerships between health care providers and academics to improve clinical education for the benefit of both students and patients. Despite this general concern, no formally structured liaison has been clearly established between educational institutes and medical care centers (13). However, there is still a need to define and explore how people in a certain organization with unique organizational cultures and structures work together and shape partnerships. So, we should consider contextual conditions.

In Iran, the government regulates nursing and other health discipline education through a series of education plans. Students can study nursing across all higher education levels from bachelor to doctorate degree. In Iran, Master of Nursing curricula focus mainly on educational units, rather than practical units. The framework and foundation of the first Doctoral Nursing program was laid out in 1995. Nurse educators, who are generally prepared at the Master of Nursing level in specific areas, teach professional courses. The clinical experience at the Baccalaureate level is spread across the first three years of the program (14).

The most commonly practiced education model implemented in Iran is the Nurse Faculty supervised practicum. Formally, clinical nurses have no responsibility in the clinical teaching of nursing students. The most important problems of nursing education in Iran include a lack of specified duties for nursing students, inconsistency between theory instruction and clinical actions, following incorrect routines that govern the clinical environment, challenges and conflicts between the clinical staff and nursing students, and the lack of willingness of the nursing staff to become involved in educating nursing students. In fact, much of the student training should be conducted by nursing staff, but in Iran, due to a lack of formal support from nursing schools, the nursing staff are not willing to participate in the education of nursing students (14). The aim of this study was to develop a substantive grounded theory of the process of forming academic-service partnerships in implementing clinical education from the perspective of academic and clinical nursing staff and managers working in two Iranian nursing schools and hospital settings.

Methods

This study was conducted during 18 months from 2009 to 2012 in Iran. We used the grounded theory method delineated by Strauss and Corbin (1998). Grounded theory focuses on identification, description, and explanation of interactional processes among individuals or groups within a given social context (15). Partnership is an ongoing process with interaction among nurse educators, clinical and educational nursing managers, and clinical nurses. Therefore, grounded theory is the ideal method for studying our topic. The participants were selected from a pool of faculty members with experience in academic-service partnership programs who were willing to share these experiences. They were recruited from two rural hospitals and a nursing school in Iran. The first participant was a nurse educator selected for her active participation in an academic-service collaborative program. Theoretical sampling was used to develop the analysis. Interviews were conducted theoretically according to the codes and categories as they emerged, until data saturation was reached. In addition, while interviewing and analyzing the data, some codes indicated the role of the clinical managers, such as head nurses, the range of newly qualified clinical educators, the

clinical environment, the role of the educational managers, and policy-making related to the phenomenon of interest, namely the partnership between nursing schools and hospitals, which theoretically guided the continued sampling up to saturation. Data saturation is the level at which no further information is obtained from present interviews and data. Data saturation is the level at which no further information is obtained from the present interviews and data (15).

Participant and setting

Individuals from two universities and three hospitals in Tehran participated in this study. Thirty interviews were conducted with 15 participants. The participants were males (n=3) and females (n=12) who ranged in age from 25 to 60 years, with 60 percent being between the ages of 41 to 60. Their roles included serving as nursing managers (n=4), educational managers (n=3), and nurse educators (n=6), as well as hospital staff nurses (n=2). The majority of the participants had a Master's degree (n=10) while the other participants were the holders of a baccalaureate degree (n=3) and Ph.D (n=2). The participants' primary place of employment was almost evenly divided between universities (55%) and hospitals (45%). Participants (45%) had an average of 15 years of experience working at a university or hospital (Table 1).

In this study, data saturation occurred at participant 13, but data collection and analysis continued to the completion stages (theoretical saturation). Two more participants were interviewed and the codes from these interviews were organized under the existing schema. Theoretical sampling was used in order to focus the data collection, enrich the categories that emerged, and guide the subsequent data collection (15). Therefore, four categories of participants were included: nurse educators, clinical nursing staff, clinical managers, and educational managers (n=15). The mean age of the participants was 45±20.

Data were collected through audio-taped, in-depth interviews. All interviews were conducted by the first author in Persian. Two interviews were used to generate data from each participant. Interviews carried out in private rooms in the workplace were the main method used for data collection, however. The mean score of the interview duration was about 52±15 min. The initial interview guide contained some general questions for clinical managers and nurses, such as: (1) how do you cooperate with the nurse educators in implementing clinical education And (2) what is the responsibility of nursing students and their educators in your workplace For clinical educators and educational managers, the questions included: (1) how do you cooperate with nurses in performing patient care and (2) how do you communicate and work side by side with hospital nurses? Probing questions were used to explore the experience of our participants; for example, we asked "how do you react to the dominant behaviours of nursing mangers?" We also asked the nursing managers "how do you deal with the nursing clinical instructors who try to escape from the clinical setting. The interviews were all transcribed immediately, read again and again, and analyzed for exploring the codes. Subsequently, if needed, further interviews were carried out to obtain additional explanations or clarifications of previous statements.

Consistent with grounded theory methodology, the literature was reviewed before the study to provide a rationale for the potential contribution of this research. To limit the effect of previous theoretical constructions on the theory developed, the literature was also reviewed after the results of this study were generated (15).

Data generated from the first two interviews were initially analyzed line by line. The process of conducting interviews, transcribing the recordings, and analyzing the data occurred simultaneously. In fact, each interview provided direction for the next one. Data were constantly compared with other data, codes, and categories as the grounded theory began to be conceptualized. Open, axial, and selective coding were applied to the data (15). The codes and categories from each interview were compared with the codes and categories from other interviews for the purpose of identifying common relationships. The purpose of axial coding was to put the fractured data back together in new ways "by making connections between a category and its subcategory" (15). These connections were made through the use

Table 1: Individual characteristics of the participants

Participants	Age (years)	Sex		Years of service as a nurse	Level of education		
		Male	Female		BSc	MSc	Ph.D.
Clinical educator	27-60	2	4	2-27	0	5	1
Nursing manager	35-57	0	4	15-25	1	3	0
Clinical nurse	25-46	0	2	10-27	2	0	0
Educational manager	40-60	1	2	17-26	0	2	1

of a coding paradigm, which focused on three aspects of the phenomenon: (i) the conditions or situations in which the phenomenon occurred; (ii) the actions or interactions of the people in response to what was happening in the situations; and (iii) the consequences or results of the action taken or the inaction (15). This process allowed links to be made between the categories and their subcategories and then selective coding was used to develop the main categories and their inter-relationships. The technique of theoretical comparisons was used to increase the researcher's sensitivity to the possibilities for codes, categories, and their dimensions (15).

Theoretical memos linked together with salient categories were generated as relationships between the concepts were hypothesized and validated. These memos were kept as a part of the research, and the data were analyzed in ongoing discussions within a qualitative research group in order to strengthen the consistency of the emerging theory. The relationship between the categories was examined and one core category was identified. The theory that occurred around the core category was a substantive grounded theory of the process of forming academic-service partnerships in implementing clinical education. The qualitative data analysis package MAXQDA was used for the initial stages of coding. We used source triangulation (nurse educator, nursing staff, clinical and educational manager) data collection methods to obtain and enhance the accuracy of the data.

Rigor

Conformability was achieved by members check providing during the second interviews. Prolonged engagement in the field of the study and member checking contributed to the credibility of the study. To increase credibility, we used source triangulation (nurse educator, nursing staff, clinical and educational manager) in data collection methods. The codes that the participants identified as failing to reflect their views were corrected. Also, in order to increase the dependability of the data, all interview texts and codes were reviewed by two qualitative nursing researchers (15). Maximum variance sampling (selecting participants with various ages, genders, backgrounds, and organizational positions from two universities and hospitals) during sampling increased the credibility and transferability of the data.

Ethical consideration

This study was approved by the committee for research ethics (NO: TMU 1391086) at the School of Medicine of TMU. Written informed consent was obtained from all of the respondents. They were guaranteed anonymity and were ensured that they could refrain from answering any question or stop the interview at any time.

Results

Based on the comprehensive descriptions given by the respondents in both the open and axial coding, three distinct and significant categories emerged to explain the process of partnership between the two organizations. These were (1) divergence; (2) conflict between educational and caring function; and (3) the creation of balance between educational and caring functions (Table 2).

Divergence

This category described a divergent and inconsistent context between the educational and service institutes. Divergence included three subcategories: organizational divergence, overemphasizing theoretical knowledge, and the invisible wall.

Organizational divergence

The participants primarily believed that clinical and academic institutes do not have well-defined responsibilities within their partnership. The respondents reported that the lack of harmony between nursing education and clinical settings causes the students and nursing educators to view themselves as "uninvited guests" with no rights and to consider the clinical staff the "authority."

On the other hand, divergence in the organizational structure between the two institutes has caused nursing managers to have no authority in implementing clinical education. A head nurse explained this point: "*Everything is under the instructors' authority and they are completely separated from us. They divide the duties between their students themselves while asking them to work in certain parts and we are not even aware of that at all.*"

Overemphasizing theoretical knowledge

According to the respondents, "overemphasizing the theoretical knowledge" is another factor that puts the two institutes in a divergent position. The participants added that the practice of placing excessive value on the theoretical component of nursing has penetrated the policy-making process of regulatory nursing bodies, relegating nursing practice to a secondary status. Based on the participants' experiences, only academic standards and qualifications are evaluated in filling faculty nursing positions. This causes

Table 2: Examples of extracting codes, categories and subcategories from raw data

Meaning unit	Codes	Sub-category	Main-category
"Everything is under the instructors' authority and they are completely separated from us. They divide the duties between their students themselves while asking them to work in certain parts and we are not even aware of that at all".	Separated decision making	*Organizational divergence*	Divergency
"I personally got my Master's degree to get rid of the clinic. I mean, for me, the only incentive for undertaking the Master's was to escape from the clinic".	Escape from clinical practice	Overemphasizing on the theoretical knowledge	
"The relationships are fading, as if we are from one tribe and they are from the other".	Two separate tribe	The invisible wall	
"When the clinical educators come, they are not familiar with the ward, and know nothing about working processes, such as admission, discharging, and the ward routines; they don't even know where the equipment is".	Lack of clinical competencies in nurse educators	Theory orientation-ignorance	Contrast between clinical and educational functions
"Because I was not fond of the clinic, I often offered conferences and talked to the students. Nursing staff were doing the rest themselves".	Lack of clinical competencies in nurse educators		
"To admit us and our students in the clinical setting, we should ignore our own wants. Sometimes I feel students are getting upset about how passively I behave, and I tell them in private that I have to do so for being admitted in the sector".	Trying to be dominate	Dominance-passivity	
"We are all forcibly entered and forcibly thrown out! I say my student has still not learned, but they say internship is over and you should go".	Lack of mutual respect	Power struggle	
"One of the things I have to point about my work was the fact that I didn't work that perfectly. I had no much expectation from the clinical institutes and always told my students: 'Work with your initiative. We are like this, so do something with existing facilities".	Being realistic and responsible	Influence strategies	Creating balance between educational and caring functions
"They cooperated with us in all possible ways. They provided us with all the equipment needed. I was not worry about whether students Un-sterilize or destroy it! We had enough. This was really helpful for students to see the equipment's were easily available. They helped us as much as we helped them".	Supportive learning environment	Mutual benefits	

those without an interest in clinical practice to be attracted to the educational nursing system. Clinical instructor 1 stated: *"I personally got my Master's degree to get rid of the clinic. I mean, for me, the only incentive for undertaking the Master's was to escape from the clinic."*

The invisible wall

Based on the findings of this study, *organizational divergence* and *overemphasizing theoretical knowledge* lead to formation of an *invisible wall* in the relationships and interactions between the staff of clinical and academic institutes.

The statements of Faculty Member 5 (FM5) and Head Nurse 1 (HN1) are fully indicative of this fact. FM5 stated: "*The relationships are fading, as if we are from one tribe and they are from the other.*"

HN1 commented: "*We have no working relations; they are a separate and isolated context – that is, they have nothing to do with us, and neither do we.*"

According to the respondents, differences in educational level between nursing educators and clinical nurses have created some discrepancies in their attitudes toward the concept of care and nurses' roles.

These differences in attitude lead to non-constructive criticism, as well as clinical nurses' belief that educators' clinical training is ineffective, mainly theoretical, and far from applicable to real principles. On the other hand, nursing instructors have criticized the nurses' performance as work-based and sometimes non-academic; they believe that such features misleads the students.

Contrast between clinical and educational functions

This category included the following subcategories: theory orientation-ignorance, dominance-passivity, and power struggles.

The two subcategories of *theory orientation-ignorance* and *dominance-passivity* are indicative of the partners' efforts to resolve the conflict using the win-loss methods. These two strategies have not been successful in this regard; therefore, the existing contrast has been converted into a *power struggle*.

Theory orientation-ignorance

Respondents in this study believed that there

was a group of nursing educators who are not interested in nursing practice and do not have adequate clinical competency; as a result, they tried covering up their weaknesses in clinical performance with their theoretical knowledge and higher positions as faculty members. These clinical educators and their students spent long hours outside the ward, which, in turn, allowed them to avoid taking any responsibility for patients' care. HN2 stated:

"When the clinical educators come, they are not familiar with the ward, and know nothing about working processes, such as admission, discharging, and the ward routines; they don't even know where the equipment is."

On the other hand, a group of clinical nurses have tried to manage their clinical activities independent of the presence or absence of students and nurse educators by ignoring them due to being engaged with clinical responsibilities and not having the willingness to become more involved in the conflict.

Dominance-passivity

According to the participants, the *domination strategy* was another conflict management strategy used by nurses who felt that the importance of their clinical skills and practice had not been understood by policymakers. This strategy was utilized based on certain factors, such as a high workload, the perception of discrimination, and personal traits, by nurses relying on their skills and expertise, as well as taking advantage of being "homeowners," a term repeatedly referenced by the study participants. Homeowners are nurses who feel they are the only authority on their ward with the right to govern the clinical setting, with students and educators obliged to obey. Professionals adopting this strategy tried to impose their training agenda on the staff. On the other side, nursing educators selected the *passivity* strategy, owing to their lack of familiarity with the clinical environment, lack of clinical competency, feeling of not belonging to the clinical environment, or lack of skills and experience necessary to manage clinical training.

Power struggles

These strategies have, however, failed to resolve the conflict between clinical and academic professionals and this unmanaged contrast rears its head obviously or more subtly in sensitive and critical situations in the form of *power struggles*. A lack of mutual respect between nurses and nursing students, a failure to provide learning opportunities to the training staff, and a negative attitude toward the other side are examples of the hidden power struggles.

Creating a balance between educational and caring functions

Perceptions of conflict in the divergent context between the two institutes also created the initial sparks of an intelligent interaction between the two bodies' staff members. A group of educators and clinical nurses had been demanding a solution to this unorganized and undesirable context. They eventually adopted the win-win strategy of creating a balance between the educational and clinical functions. This category included two subcategories: *influence strategies* and *mutual benefit*.

According to the respondents, a group of nursing educators established a communication bridge on divergent ground between academic and service activities, and created a balance between the two to the furthest possible extent. Since nursing educators have no official position in the clinical environment, they were seeking sources of informal power through the use of influence strategies.

Influence strategies

The influence strategies included "taking responsibility," "acquiring clinical skills," "attracting nurses' participation in clinical training," "assertiveness," and "being realistic."

Comments by HN2 demonstrate the reason for the effectiveness of a nurse educator: *"One of the major successes of Ms 'A' was related to possessing the necessary clinical competency. She was so skilled and very responsible. She was attentive; too…She was really familiar with the ward policy! She had been working here for years and had good relations with the staff! And such a relationship has made working easy for both sides."*

A clinical educator, FM3, commented: *"When students ask questions, they share many of their experiences with the students. This will help the students learn better and a cooperative atmosphere is fostered in the ward*."

Clinical educators were realistic in trying to make the most of the existing facilities, instead of complaining or blaming the other side and entering a power struggle. *"I did not have many expectations from the clinical institutes and always told my students: 'Work with your initiative. We are like this, so do something with the existing facilities.'"*— EM1

Mutual benefit

As a result of clinical educators' penetration of the clinical environment, their training

has been presented as *beneficial* and *patient-centered*. In this form of partnership, the patient is the center of attention for both the educators and nurses. By emphasizing practical training and time management, nursing instructors can make a balance between academic and service activities, handle the responsibilities assigned by the ward quite well, and account for part of the care they have undertaken. On the other side, nursing managers and clinical nurses shared their facilities with the students and their educators. *"They cooperated with us in all possible ways. They provided us with all the equipment needed. I was not worried about whether students would un-sterilize or destroy it! We had enough. This was really helpful for students to see the equipment was easily available.*" —FM5

Core variable: According to Strauss and Corbin (1998), the core variable emerges alongside the continuous analytical comparison and the collection of supplementary data, and can serve as a concept in addition to the existing categories. The core variable in the current study, balancing power, enabled the researchers to integrate the concepts pertaining to the partnership processes between clinical and educational institutes. Balancing power is the product of an intelligent interaction between nursing educators and the clinical environment, and an attempt to establish communication paths and penetrate the clinical environment.

According to this approach, the grounded theory of balancing power can be expressed as follows: *Organizational divergence* described structural defects in the communication path between the two institutions. *Overemphasizing theoretical knowledge*, which has penetrated the practice of setting regulations, was another factor leading to conflict between the academic and clinical staff. Psychological reactions to communication issues between the two institutes formed an *invisible wall* between the partners' staff in the mental and functional dimensions.

Both sides of the partnership confronted the conflict using the win-loss approaches of *dominance-passivity* and *theory orientation-ignorance*. Unmanaged conflict remains hidden and reveals itself as a *power struggle* in critical situations. A group of nursing educators strived to transform the struggle over power into *balancing power*. Thus, using the win-win strategy, they attempted to resolve the conflict between academic and service functions. A balance of power was established by acquiring informal and personal sources of power as well as strengthening and empowering the other partner. Creating a balance between education and service functions via the win-win strategy brought *mutual benefit*. The partnership was formed at the individual level, not the institutional level, and the participants tried to compensate for shortcomings by sharing their strong points, which included the clinical skills of the nursing staff, the use of nursing students to cover nursing shortages, and the application of nurse educators' skills and knowledge to the hospital staff development programs. As a result, both sides of the collaboration took advantage of the benefits and capabilities of the other side in providing patients care, and a balance was created between the educational and clinical functions.

Discussion

The results revealed that conflict between clinical and educational functions was the main concern of both sides of the partnership in working to form a collaborative relationship. The concept of balancing power as the core variable represents the conflict-resolution and balance-centered approach of collaborative academic and service functions. The findings from a study performed by the same research team, based on a systematic review of the literature, showed that one of the primary steps in implementing partnership programs between educational and clinical institutes was turning the competitive relationship into a collaborative one. Related studies noted some ambiguity in terms of the boundary between the concepts of conflict and competition. Bounding (1962) described the conflict as a subset of competition, which is created when the two units are likely to be inconsistent and incompatible in their mutual relationship. Conflict is a competitive situation in which the two sides are aware of the discrepancy in their desire to reach a consensus with the other side. On this basis, it can be stated that a disparity between behavioral units and the willingness to achieve a consensus is the competition-causing agent, which will be converted into conflict when the two sides become aware of it. Investigations show that although setting up the institutional partnership is of great benefit, it can itself lead to feelings of disappointment and frustration, since partnership requires the establishment of communication and the implementation of methods, procedures, and new structures that are quite different from those that existed before the collaboration (3). A simple rule states that the earlier the conflict is identified, the more easily it can be managed (4). Therefore, it is imperative that before beginning the cooperation, underlying competitive factors are resolved as conflict-causing agents. Accordingly, it can be concluded that as the study's core variable, the concept of

balancing power addresses the conflict-managing strategy before establishing the collaboration.

Partnership is defined as a mutually beneficial and well-defined relationship entered by two or more partners to achieve common goals (8, 16). In the present study, the *mutual benefit* sub-category was the final product of the balance of power. The results demonstrated that by overcoming the obstacles in partnership formation between the two institutions, both sides were eventually able to benefit the other partner based on their own facilities and capabilities.

In agreement with these findings, many studies have indicated that an effective partnership between the clinical and educational bodies leads to mutual benefits. Increased educational capacity within the colleges of nursing (4, 5, 17, 18), enhanced nursing research and the development of evidence-based nursing (10, 19, 20), improved clinical credibility of nurse educators (17, 20), provision of an opportunity for staff development and in-service training for clinical nursing employees (1, 10), effective familiarization of students with clinical environments, and creation of a supportive educational environment (1, 9-11) are some of the mutual benefits mentioned in the studies.

Considering that partnership has occurred at the individual level, rather than the institutional level, in this research, the benefit has not been managed strategically, but has been confined to merely providing facilities in the hospital units without any profit sharing between the institutions.

During the process of setting up a service-academic partnership, task force groups are formed, acting as organizational channels and facilitating the interaction between the two institutions. Members of these groups include representatives from the partner institutions with a wide range of interests and expertise (1, 11, 19). The latter groups are referred to as "ad-hoc work groups" (19), "task-oriented focus groups" (21), "working groups" (22), "committees," and "sub-committees" (1). This study also found that the two institutions lacked a structural relationship, which led to the creation of conflict between educational and clinical functions, showing the challenging context underlining this partnership.

Nursing is a practice-oriented discipline, with the practical aspects forming the main sphere of the profession. A gap between the theory and practice will contribute to a number of negative consequences across the profession (23). Likewise, this study showed that the power struggle between clinical and educational teams was one of the negative consequences brought about by the theoretical orientation of the clinical educators. Clinical educators' distance from nursing performance resulted in conflict between this group and the clinical nurses. In addition, educators' acquisition of clinical competency was one of the mechanisms identified by the participants that led to a balance between academic and service functions.

A number of studies in Iran and other countries have also illustrated the fact that effective clinical educators should be able to turn theory into practice (8, 13).

The *dominance-passivity* sub-category was referred to as the nurses' dominant behaviour toward the nursing educators and students, arising from the social and cultural status of the nursing profession in Iran. Iranian society, like many other East Asian societies, is family-focused and a traditional perception of women working outside the home and, especially, being employed within the nursing sector prevails. Typically, in family-focused societies, a woman working during the evening hours or night shifts is considered undesirable (8). "In Iran, working as a nurse educator overcomes the latter obstacle and provides enhanced social status and financial rewards. Therefore, in contrast to the western countries, many Master of Nursing graduates prefer to pursue careers in the academic rather than service sector" (8). Our findings also revealed that faculty members without the appropriate clinical and functional qualifications for a service position who took advantage of the increased benefits offered by this environment played a role in the formation of *the invisible wall*, resulting in the dominant behavior of faculty members toward clinical nurses.

Conclusion

The results of the present research showed that in implementing clinical education, academic-service partnerships have been formed within a challenging context in Iran. These challenges were rooted in defects in the organizational structure as well as in the institutions' traditions and beliefs. Conflict management was performed using the balance of power, which shares many similarities with the key steps of partnership formation highlighted in other studies performed at the international level. Like other collaborative programs reported in nursing texts by other countries, partnerships in the organizational context of health institutions in Iran have also created benefits for both sides, although the benefits were at the individual level, not the institutional level. Our findings emphasized the importance of nursing educators' role in establishing partnership programs. The

acquisition of clinical competency and utilization of effective communication skills were the keys to success in forming an efficient partnership with the clinical institute. To create an influential and long-lasting partnership, it is necessary to reform the institutional structure of both the clinical and educational bodies, so that the interaction between the two can be meaningful and transparent. Pragmatism and prioritizing nursing functions in setting the institutional rules and regulations resolve the communication challenges as well as the existing contrast between the two institutes within this cultural context. The mutual benefits derived from the implementation of partnership programs should be highlighted at the institutes' managerial level to enhance the effectiveness of the aforementioned programs. The present findings will help the managers and policy makers to consider partnership programs in the institutes.

Data were collected from a small participant pool from two universities in Iran (Mashhad, Tehran), making the study geographically limited. In addition, generalizability of the findings is also limited due to the small, purposeful selection of participants. Hence, the findings may not be reflective of experiences of nurse educators and clinical nurses in other hospitals in the counties, states, or nations. As such, the implication of the findings for nursing practice may not be applicable to all institutions.

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