CARING EXPERIENCE: A NURSING FACULTY'S EXPLORATION

by

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Caring Experience: A Nursing Faculty's Exploration

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Abstract

Prompted by the pending implementation of a new nursing curriculum at North Island College in which caring is seen as the "attitude and activity of nursing [which] will be considered in every course" (Collaborative Curriculum, 1992b, p. 10), this qualitative case study explores caring as perceived by the nursing faculty. Through the use of individual semi-structured interviews and a Caring Workshop, the realities of caring as experienced by the faculty are used to develop strategies for assisting students to develop as caring professionals.

A review of the literature reveals an emerging science of Human Caring in which caring is perceived as the core value of nursing. This science is evolving within a profession whose practitioners are predominantly female working within hierarchical structures which are only now beginning to organize environments conducive to and valuing effective caring.

Themes reflecting the caring realities of each of the faculty were, in ongoing consultation with the faculty, constructed using the individual interview transcripts. Each faculty's experience of caring is addressed by providing a story from her transcript and by giving examples of her experiences as they relate to that faculty's themes.

Caring themes shared by all the faculty were constructed from all the interview transcripts and from input received at the caring workshop. These are addressed by providing examples from the interviews and the workshop as well as relating the themes to the literature where appropriate.

Finally strategies for assisting students to develop as caring professionals were developed by the faculty at the Caring Workshop. Through sharing their caring stories and individual themes, the faculty developed a sense of their collective caring history and how this knowledge could be used to incorporate caring into all facets of the curriculum. The research concludes with a discussion of the strategies and ideas for implementing them.

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Prologue

The decision of where to include a very personal account of my caring history and the themes constructed from it, completed before the other participant's were interviewed, was not an easy one. I felt that it had to be included because of my position as a member of the faculty with whom the research was conducted. It also had to be part of the research because it would provide a basis for comparing my changing perceptions of caring as the study progressed. It would also serve as a means of defining the place from which I came to the research in relation to caring. I also felt the need to share the stories because they are not about me but about a process of growth in understanding facilitated by the many people I have been privileged to be caring with in my practice as a nurse and this is a way of acknowledging that.

I considered placing the caring history and the subsequent theme constructions as an appendix but this felt like pushing an important part of the process to the back and diminishing its importance. I also tried placing it before and after the literature review which gave the impression of not being informed or, alternately, of being informed by the literature. Although, my reading has influenced how I perceive caring, I did not want the stories to be seen as an introduction to or epilogue for a survey of

the literature. I wanted them to be read for what they are, an account of rich experiences informing the process of my attempts to become a caring professional.

I was delighted by the inspiration to look up the word prologue in the dictionary. This occurred to me after reading the Prologue of Elvi Whittaker's book The Mainland HAOLE: The White Experience in Hawaii. The prologue set the stage for me. The dictionary defined prologue as "1. An introduction to a play or poem etc. 2. Any preliminary act or event etc." (Webster's New World Dictionary, 1990, p. 471). These definitions were the answer. My caring history felt like an introduction to what I hoped would be research revealing the drama of nurses' lives as they learned about caring. It was also a preliminary act of discovery describing events which occurred over a period of years but were still pertinent to my practice as a nurse today. Hence the decision to have a prologue and set the stage, so to speak.

The many highly personal tasks I perform for others such as brushing their teeth, cutting their toe nails, bathing their bodies, and changing soiled linens, in the daily routine of being a nurse provide little motivation for my continuing in the profession if divorced from my feeling of caring. The caring of which I speak is, for me, a feeling that impels me to act for and with others and a feeling through which I am aware that people matter. It is an overwhelming feeling of being where I am supposed to be at a particular moment in time. Prompted by a decision, of the nursing

faculty at the community college where I am employed, to adopt a new curriculum based on caring, I began to read about caring and reflect upon my development as a caring professional. Deeper reflection on caring in general and on my caring history in particular, was necessitated by my decisions to enter a Master's program and to choose caring as a research topic. This has in turn led to a fuller discovery of what caring means to me, how it has affected my nursing practice decisions and how it has shaped my teaching as a nursing instructor.

Remembering experiences that remain vivid after many years, has proved useful in exploring the process of my development as a caring nurse. I have written the stories as they occurred to me hoping to simulate an interview. The theme constructions are an attempt to clarify what it was in these incidents that informed and expanded my perception of caring.

Eppie's Caring Journey

> My earliest recollections of caring as related to nursing occurred when I was six and eight years old. At six years old I was admitted to the hospital to have my tonsils removed. I remember asking my mom, who even though she was a full time teacher stayed with me most of the time, if it would hurt. She told me that my throat would be sore for a little while, that I would feel like throwing up but that in about a week I would be better and I wouldn't have any more earaches. I remember that the nurses were dressed in white, and I remember having to stay in bed prior to surgery. I also remember being in a ward with many other children and one of them, a boy named Bobby, started pushing my bed around the ward(with me in it.). I was very worried about this not being right. My last

memory of that hospitalization is of wanting a drink of milk as soon as I woke up from the anesthetic. The nurse said that I may be sick if I had milk but that if I really wanted it she would get me some. I did. She got me the milk, my mom helped me drink it and then I was sick. Still I was very glad to have the milk, my favorite food at that time.

At eight years old I had my appendix removed and this whole process is very vague to me except for two things:

- one day I felt like I was going to throw up and I had the kidney basin under my chin. The head nurse came in and said I wasn't going to throw up and she took the basin away from me and put it out of my reach. I was very worried about throwing up all over everything but I didn't. When I think about this now I realize that this action on part of the head nurse was not one that made me feel cared for.
- I remember my dad, who worked away from home during the week, coming up on Sunday night playing snakes and ladders with me for what seemed a long time. I felt cared for and loved.

At the age of eighteen I entered the Nursing School at the University of New Brunswick. I do not have any recollection of even specifically talking about caring as part of the curriculum but I do remember that we were to consider the patient as a whole person; that we were to be professional; and that our interactions with patients were to be therapeutic at all times. My most powerful experience of caring during four years of nursing education was through a professor in pediatrics. She was the first professor to call us by our first names as we did her. She talked to each of us individually each week (25 in the class). She described nursing as caring and demonstrated this in her dealing with patients all the time. She stressed the importance of being knowledgeable about patients' needs during illness, about ways of assisting them to deal with painful procedures and horrifying diagnoses with dignity and control and about being with people where they were. I particularly remember her interactions with the parents of a new born baby boy who had spina bifida requiring surgery which would most likely cause the child to be paralyzed permanently from the waist down. She listened to their concerns that he not be treated differently from any

other child. She assisted the parents in developing a strategy for discussing this with the doctor and arranged for the doctor to spend time with them. The professor assisted the parents with their concerns and did not impose her own views ensuring the family were in control of the situation. She modeled caring and for the first time I had an inkling of what nursing was really about (this was in the third year of the program).

Since graduating from University in 1970 I have worked many places and had many experiences that have been paradigm cases (Benner, 1984) for my understanding of caring. They have had the effect of "turning on the light", confirming or disconfirming some of the ideas I had developed as a caring professional. The fact that many of the situations are still crystal clear in my mind even though they have occurred over a period of twenty three years attests to their impact on my experience of caring in nursing. The following is a description of the experiences that have influenced and shaped my understanding of caring.

As a new graduate in 1970, while working in a 120 bed acute care hospital, I requested to have as part of my patient assignment, a man who was labeled by several of the nurses as very difficult, a whiner, a perfectionist. I was starry eyed and thought I could "do something" with him and for him. He was very ill due to having contracted a severe infection after abdominal surgery. He had to have the infected surgical wound irrigated several times a day and a new dressing applied. He had to deep breathe, turn and cough every two hours which was very painful for him. He was receiving intravenous fluids, and he had a foley catheter draining his urinary bladder. Although he was very weak he was also very particular about how the wound irrigations were to be done, how the dressing was to be changed and how he wanted to do his exercises. He gave directions every time anyone did these things for him even if they had done it many times already. As a "new" nurse I was happy to let him tell me what to do. He was able to give me many hints and I still use some of them to this day while changing dressings and irrigating wounds. I felt that he needed to tell me how to do these things each time as he was then in control in a small way in a situation in which he must have felt very powerless. I remember wanting to hurry

one day while doing his wound irrigation and not listening to his directions while replacing the dressing. Of course, the dressing fell off within minutes and I had to do it as he had originally wanted in the first place. I remember talking to him about how I had been in a hurry and that his way was much better. I did not feel like I did anything particular for this man except to respect his wishes and listen to his concerns. After being assigned to him for four days, the head nurse took me aside and said "You have really made a difference in Bill (a pseudonym). He is not ringing the bell so much and he is less demanding when we are in the room with him". I remember thinking how little I had really been able to do for Bill but realized that in caring about how he felt and respecting his need to direct his own care I had made a difference. I thought this was what all nurses naturally did and it was very disconcerting for me to actually think that this was not the case.

While nursing in Malaysia, from 1971 to 1973, I had to make many two to three week trips into jungle villages that were often three days walk from the nearest road. The Orang Asli (Original People) with whom I worked lived in houses on stilts built of bamboo with atap (woven) roofs. They had no running water or sanitary facilities. During one of my visits to inoculate children for polio and small pox, a young mother brought her baby to me who had thick purulent discharge oozing from his right ear. She told me it had been this way for a long time. I had injectable penicillin with me so after giving the baby a small test dose, I gave him the regular dose for his weight and height and was able to repeat it over the next several days while working in the village. The baby's parents also had the local indigenous healer attend the baby. I watched him spit in a cup (the people in the area had a high incidence of tuberculosis), mix some leaves in with the saliva, pour water in this from the river and then wipe it all over the baby. After three days the baby's ear was no longer draining and there was no evidence of fever or other signs of illness. The parents were thrilled and told me that my medicine and the indigenous healer's together were very powerful.

I realized that my concepts of what constituted good health practices were very different from theirs but the healer

was always there and I would probably never visit there again. Instead of contradicting the parents I asked the healer if he would like to take part in a training program for indigenous doctors which was held at the main hospital center several times a year. He indicated his willingness to do so and I enrolled him upon return to the hospital. He attended the program and learned about microorganisms and how they are transmitted among other useful things.

The importance of providing people with enough information to make healthy choices for their lives was and is a central concept to my nursing practice but it felt more caring in this situation to deal with the healer and his practices instead of contradicting the family's faith in the one consistent healer among them. I also recognized that I was not aware of all the remedies he used and many of them may have been very useful if extracted from local plants. This experience opened for me a whole new world of ways of knowing and being that I had not imagined existed. It also demanded a new level of caring that needed to be free of preconceived ideas and required me to meet people where they were if I was to be instrumental in assisting them to improve their health in ways they determined.

Approximately three years later another family taught me more about caring. On a busy Friday evening in the emergency room of a small acute care hospital in northern B.C., Joey and Bobby presented themselves requesting that Bobby have her IUD removed as they wanted to have a baby. They were both dressed in soiled jeans, Cowichan Indian sweaters, and large rubber boots. Their hair was uncombed, their nails dirty, and their breath smelled strongly of alcohol. They spoke loudly in sentences punctuated with swear words. Bobby was a First Nations person and Joey was white. While waiting for the doctor to arrive, I took the opportunity to discuss their decision with them and get to know them better. I learned that they were both from large families, they were alone together in the town, having recently moved there from a northern reserve, and they were determined to start a family. Joey did not have any children and Bobby's only child, a three year old daughter, lived with Bobby's parents on the reservation. Bobby and Joey were currently employed in the

fish packing plants and expressed confidence that they could afford a baby. After the IUD was removed by the doctor, I talked further to Joey and Bobby about pregnancy. I gave them pamphlets about prenatal classes and about nutrition during pregnancy. They left the emergency room thanking us for our time. The next time I saw Bobby and Joey was on the Obstetrical Unit of the hospital. I had transferred there, two months previously. I was in the case room when Bobby gave birth to a healthy baby girl. Bobby and Joey had attended about half of the prenatal classes and this was evident in their successful attempts to do the breathing exercises together. During the five days of hospitalization, Joey was present as often as visiting hours allowed. The fact that he was now unemployed seemed unimportant to him. They were like sponges learning all they could to look after "Gail". Bobby was determined to breast feed and Joey bathed Gail and learned to change her diapers. I had the opportunity to see Bobby, Joey and Gail again. I had begun working in the local Public health Unit and was working at the weekly Well-Baby Clinic when they appeared for Gail's first immunization at the age of three months. Gail was well within the normal developmental ranges in all areas, Bobby was still breast feeding her. Joey was still unemployed. Their clothes were still soiled, their hair uncombed, and their language still colorful. Gail was quiet, smiled readily, had no signs of diaper rash, and fussed only slightly while having the DPT injection. Bobby immediately offered her the breast and she sucked contentedly during the remainder of our interview. Joey and Bobby made an appointment for her six month immunization and as they were leaving told me they wanted to have about ten children. I moved from that small town about a year after this last encounter. I have never seen Bobby, Joey or Gail since but I often wonder if they have ten children and how they are all doing.

The words written on paper about this story are so bare because they do not capture the gratefulness I feel nor show the tears in my eyes when I think of it. I constantly had my stereotypical thoughts challenged by their progress as a family. The boundaries of my caring abilities were expanded again!

Assisting parents with the labor and delivery of their child is a favorite part of nursing for me. At a seventeen bed hospital in northern interior B.C. much of the nursing work involved labor and delivery coaching. I was always ready to help parents with the breathing and found it especially challenging and rewarding to assist moms who were losing control. I merrily carried on with this practice until one day when talking with a nursing colleague she described how it was important for her to assist both parents in dealing with labor so that the dad as well as the mom would feel involved and that they had accomplished something together. It hit me like a ton of bricks that I was not caring in these situations. I had deprived families of sharing this hard work and thus of reflecting back on it as a job well done together. I then was able to give up a role that I really cherished so that the Dads who were able to could play the part they wished. My colleague was very instrumental in assisting me at seeing that caring meant assisting others to do as they wished not as I wished.

During a twelve hour night shift on a female medical/surgical ward in an acute care Vancouver Island Community hospital, I had opportunity to learn how far I still had to go to be caring. It was a very busy night. Three or four patients were very ill. There had been two admissions which took a lot of time and the supervisor could not find any extra staff to help. I had phoned a physician to request an order for pain medication for a patient and he gave me an earful about disturbing him at home when someone could have gotten the order when he was in that morning. During all this, Mrs. Brown (a pseudonym) had been ringing the bell about every twenty minutes asking for the bedpan. She had done this about three times and she voided about 2 tablespoons of urine each time. I remember going in the fourth time and condescendingly calling her dear every time I addressed her. I remember barely, if at all , hiding my impatience. She started to cry and told me how worried she was about wetting the bed and how lonely it was in here without her husband. At this moment I recall very clearly thinking to myself "What am I doing here?" I had never felt this before in 16 years of nursing practice. I then explained to her that I was

very busy but would come back and talk to her in an hour. I also told her I would arrange for her to get the plug in phone so she could talk with her husband. If she had not started to cry and talk I would have continued on being officious and impatient as well as condescending. I thought of this incident over the next several days and realized that being uncaring with Mrs. Brown took a lot more energy in worrying afterwards than being "with" her would have taken in the first place. I also now see in this incident many of the things that make it difficult for nurses to care and which need to be talked about so change can occur, such things as inadequate staffing levels, too little money, too little power, and not enough time.

In my current position as a nursing instructor, I have learned about caring from the students. As part of the current curriculum, the students were taught a conceptual model of nursing upon which patient assessment was based. I have never felt comfortable using the conceptual model myself but was compelled to teach it as it is fundamental to the Nursing Program curriculum. Several students in each class I have taught have had difficulty using the model effectively in assessing patients. I had attributed this to either ineffective teaching on my part or lack of effort on the students' part. One day a student asked me if the students in other nursing schools had the same trouble with the model. I was appalled to comprehend that I had neglected to provide students with information about alternate nursing models which may have been more appropriate to their individual learning and thinking styles. In my desire to prepare them with the information they required to understand this particular view of nursing, I had forgotten and indeed felt unable to give them the advantage of choice in the use of different nursing conceptual models. This felt very uncaring and I was relieved when the decision was made to adopt, in September 1993, a new curriculum in which the philosophy commits faculty to providing the students with choices and to plan learning activities with them.

As a student currently studying for a Master of Arts degree in Education, I have had time to reflect on caring and what it actually means to me. I know that nursing for me is nothing without it and everything with it. It is through the

caring interactions described above, and many left undescribed, that I have felt an overwhelming sense of awe and wonder at the connectedness caring can create. It feels very close to a work of art to me. It becomes a way of life and affects how I try to be with everyone and causes me distress when I fail. I perceive this as good and strive for it in all my interactions.

Eppie's Themes

As I explored the caring experiences that I recalled and committed to paper, and began to construct themes from them, I become increasingly aware of how, for me, caring is related to control, creativity and connectedness. By having control of situations and ensuring people with whom I am interacting also retain control, we create pathways to wellness together and in doing so become connected in the caring relationship. Although I will explore my caring history by organizing the discussion using the themes Caring as Control, Caring as Creative and Caring as Connectedness, they are not separate in my mind but interrelated and equal in their relevance to my understanding.

Caring as Control

As I read, sorted and sifted through my caring history, I recognized that I felt cared for when given control and I felt caring when I was able to leave control with others where it belonged. This is a poignant revelation for me especially as I work in a profession where people are often very vulnerable and at risk of being controlled, manipulated and coerced to meet my ends not theirs

(Bevis and Watson, 1989; Benner and Wrubel, 1989; Kreisberg, 1992).

Caring and Control of the illness/wellness experience

My early recollections of illness and hospitals provide evidence of how even as a small child, I felt cared for when "in control". My parents figured prominently in this and gave me the support and information I needed to exercise some control over a situation in which I was basically helpless. My mother prepared me for the surgery and answered my questions about pain truthfully giving me the information I needed to cope with what was going to happen. My father spent time with me making me feel special. I think I may have had a sense of control even in this because I was able to command my father's full attention.

The roles nurses played in my perception of caring during these early illness experiences are distinct impressions. The nurse who gave me the milk I wanted after surgery did so only after warning me of the possible consequences of drinking it but left the decision with me, a six year old. Benner (1984) characterizes this nurse's action as "maximizing the patient's participation and control in his or her own recovery" and goes on to comment that "behind this .... is a determined effort to maximize the patient's control over [her] life" (p. 58-59). I do not credit this one incident with forming my consequent interactions with patients but I can recognize its

relation to my experience with Bill. My ability to accept his instructions about changing his dressings, irrigating his wound, and assisting with his exercises, was informed by my recognition of his need to be in control in a very powerless situation.

The experience of having the kidney basin removed when I was fearful of vomiting over everything, still has the effect of making me feel powerless and angry. I cannot speak for the head nurse who acted in this way. I see in her actions a desensitization to my human condition in illness and suffering (Tanner, 1990; Benner and Wrubel, 1989) and her failure to recognize that I was controlling my feeling of nausea in the only way I perceived was available to me. An understanding of how this can happen became evident to me when reflecting upon the episode in which I became impatient with the elderly woman who was constantly asking for the bedpan. There are many issues imbedded in this story, some of which will be addressed further on, but in relating it to my feeling of the necessity of personal control in the illness experience, I can see how the woman was attempting to deal with a very scary experience for her. By finally listening to her and understanding this I was able to modify my response to her and meet her in a more caring place.

The couple who presented themselves at the emergency room to have the woman's IUD removed, placed themselves in a position of vulnerability regarding control over their choice to have children. My very first reaction was to deny them their request because I was tempted to judge them as not being capable of being responsible

parents. I could have easily controlled this, at that moment in time, by advising them that the emergency room was too busy and that they should make an appointment with their doctor. All the while thinking that when they were not drinking, they would reconsider their decision. I also wanted to give them information about Alcoholics Anonymous. I concluded, without evidence, that they were requiring this service. I did not follow this course of action but instead respected their decision to have a baby and attempted to provide information that would assist in ensuring a healthy pregnancy. I was not consciously aware at the time of the reasons for my actions but looking back now I feel that again I was aware that to be caring I had to respect the couple's decision. Their consequent growth as a family, confirmed for me that caring about their control of their lives was an important way for me to be as a nurse. The whole occasion also made me shamefully aware of the many stereotypes I was harboring.

Choosing to provide the indigenous healer in Malaysia the opportunity to add to his healing skills also reflects my inclination to ensure people have control over their own health decisions. I cannot say that neglecting to discuss how communicable diseases are transmitted with the family was appropriate nursing practice but I do feel that this course of action was a result of my commitment to leaving control in their hands.

The strong relation between caring and control in my conception of professional nursing is also exemplified in the

adjustment I made to my practice in caring for families in labor. The relinquishing of the major role I took for myself with laboring families could also be attributed to getting out of doing exhausting work. In view of my past interactions with families, I am inclined to discount this motive and again understand the role of control in shaping my decision.

Caring and Control of Learning Experiences

The statement "I do not have any recollection of even specifically talking about caring as part of the curriculum" has special significance for me. It is of interest to me that I do not remember any learning that took place in the classroom where my control over content was minimal. Lecture information was exam tested and skills practiced were evaluated in the clinical area by the professors using behavioral objectives. The way I remember learning about caring was experiencing what I perceived as caring interactions with a nursing professor and watching her interact in caring ways with other students, with patients and their families. I am convinced that the professor not only lived caring but consciously modeled it. What I learned from observing her was not exam testable. It was not necessarily observable as a change in my behavior, but it was a change in understanding that I chose and controlled.

The story of omitting information on conceptual models of nursing has now become a symbol of uncaring for me because of the control I denied students. This not only deprived students of choice

but gave me power over them in many ways - the power to appear superior in knowledge thus rendering them dependent on me, and power to fail them for not using the program conceptual model of nursing "correctly". This example of teaching by excluding certain information or of a null curriculum illustrates how depriving the students of concepts and skills "will have important consequences on the kind of life that students can choose to lead" (Eisner, 1979, p. 92).

Caring and Control of Nursing Practice

My feelings of frustration expressed in the story of the elderly woman with whom I was impatient, I again interpret as arising from feeling uncared for in a situation fraught with factors beyond my control. This incident is one of many I could document in which doctors continue to act in an authoritarian manner, nurses feeling out of control exercise it unnecessarily over patients, and administrators in hierarchical management structures make policy and staffing decisions without input from those who are most directly affected - nurses and patients.

Caring as Creative

The stories narrated in my caring history do not speak to me solely of control. I also feel a sense of creativity in many of the situations. In the stories depicted, I remember feeling overwhelmed by a creative tension and perhaps that is why they are strong memories for me.

Caring and Creating Relationships

When I think of the young couple whose growth as a family I witnessed, I see not only issues of control but also the creation of a relationship between the man, woman and myself. The basis of the relationship was a caring commitment to having a healthy baby. Together, the parents and I began the adventure by focusing on pregnancy and what they could do to ensure a healthy outcome. Together, we learned about baby Gail and together we watched her grow. Although I have not had contact with these people for many years and the contact I did have with them was professional, I still use the gifts the relationship gave me in interacting with others. I try to remember to put my stereotypes aside and meet people where they are.

The greatest motivation for me in assisting families about to have a baby was the creation of a special relationship with the mother. The mothers often became dependent on my abilities to assist them in dealing with labor pains and remembered my help for many years later in relation to the birth of the child. This special feeling of having dealt with a stressful situation successfully together creates a bond, a bond which I came to realize rightfully belonged to the family. I am now very critical of those situations in which I intervened unnecessarily and by doing so displaced the father, possibly depriving that family of a strong bond that would be a source of strength in their relationship. My relationship with a nursing colleague was a creative one in this instance for a comment

of hers initiated a whole process of change in my thinking and practice around caring for and about families adapting to the experience of childbirth.

Caring and Creative Decisions

I see in my interactions with people as I meet them in my professional nursing role, opportunities seized and opportunities missed to make creative decisions based on knowledge and caring. Creative decisions, for me are caring ones in which individuals are able to make decisions about their health and how they will pursue it.

Many of the decisions I make which I consider caring and creative, are spontaneous and do not follow a particular pattern. This is true of my decision to ask the indigenous healer to come to a health workshop. In my desire to care about the family and not to discredit the local healer, I seized upon the workshop idea and evaluated it on the spot as an action of choice. This decision not only met my need for ensuring information about communicable diseases would be provided to the community, but it also had the impact of maintaining the indigenous healer's integrity, the family's choices and my caring.

My initial interactions with the elderly lady were routine and determined by my frustration at the difficult working situation in which I found myself. By continuing to ignore the woman's frequent

requests for the bedpan as a cry for attention, I became trapped in a cycle of interactions, unsatisfying to both of us. By finally listening to her I was able to create in my mind an understanding of her situation and thereby suggest the phone call to her husband and to reassure her that I would return in an hour. By recognizing and caring about the woman's feelings, I was motivated to create caring alternatives for meeting her needs.

Caring as Connectedness

In the situations in which I have been uncaring or felt uncared for, I have also had a feeling of dissonance or disconnection not only from the people involved but also from the profession of nursing as well. On the other hand, my feeling of *being with* others when I am caring and cared for is palpable and satisfying.

Caring and connecting with others

When I realized how I had deprived the students of information about nursing conceptual models, I now think I also felt uncaring and disconnected from them. I had failed to understand their learning needs and, in fact, prompted by the need to meet curriculum criteria, I was also reluctant to give them the information. This felt and still feels uncaring and disconnected, because I put my needs and curriculum requirements before the necessity of being an advocate for change in the nursing program. I now wonder how often this happens to me and as a result of this reflection may be

able to recognize the feeling of disconnectedness as a warning sign for looking at situations and be motivated to reflect upon what I am actually doing.

On the other hand, the feeling of connectedness I have with baby Gail's family is still a part of my being and influences how I meet others. This is also true of the relationship I established with Bill many years ago as a new graduate. The feeling of connecting in the others' worlds has broadened my understanding and removed some of the barriers to caring that I constructed.

Caring and Connecting to the Profession

The professor who became my model of nursing and caring also provided for me a picture of what it meant to be a nurse. This, in turn, established a connection with nursing as a caring profession as did my early recollections of being cared for by the nurse who gave me a choice in my illness experience (Benner, 1991; Bevis and Watson, 1989). The head nurse who complemented me on how Bill's behavior had changed since I had been assigned to care for him, also provided a feeling of connectedness to the profession. She indicated approval of the caring in my care of Bill and by the very act of speaking to me about it validated my feelings even though I was disconcerted by the fact that maybe all nurses did not act this way.

My feeling of disconnectedness from the profession is evident in my wondering "What am I doing here?" when dealing with my

ineffective interactions with the elderly woman. The situation was one of dealing with factors over which I had no control. My choice of nursing as a profession had placed me in this untenable position. I wanted to disconnect from it. My inability to be caring in the way that was meaningful to me posed leaving the profession as a distinct possibility, a means of coping. I wonder how many nurses have been faced with such a decision and chosen to care for themselves by disconnecting?

Conclusion

This reflection upon my caring history has been very exciting in that I realize there are as many ways of perceiving caring as there are people attempting to live it in the nursing profession. The more knowledge I have of others' experiences, the more ways of being are available to me in choosing to meet the other as a caring professional. The possibilities are endless and I want to share them with students.

CHAPTER I

Background and Statement of Purpose

> The faculty have a lot of work to do. Our caring travels as a faculty have really just begun and as we learn a lot more about it, not only about caring but there is a whole other side of learning how to think about caring, how to express caring, and working to develop a trust relationship that helps to identify uncaring and works with that (Participant Quote, 1993).

Nursing Instructors are charged with not only ensuring that students become competent in providing nursing care but also with assisting students to provide that care in a caring way. Instructors are often required to evaluate the students' caring development even though "most nurses find it difficult to define caring" (Mangold, 1991, p. 134). This difficulty may arise, in part, from the use of the term care to describe a whole range of interrelated activities and ideas. Actual nursing skills such as giving bed baths, injections, and engaging in nutrition counseling, to name a few, are described as nursing care (RNABC, 1990). The person who provides hands on care may be given the title of care giver. These are essential components of care in nursing but are not the aspect of caring which is the focus of this research. The caring that is the focus of this research is not easily defined. It is not the purpose of this paper to produce a definition, although a review of the literature will reveal how it is defined by others, but rather to explore the nature of the lived experience of caring. The caring under consideration here has

variously been described as that which impels one to act, the caring that sees the other's reality as a personal possibility, the caring that means people matter to nurses, the caring that the literature describes as the essential nature of nursing manifested in co-presence and love (Noddings, 1984; Benner and Wrubel, 1989; Davidson and Ray, 1991). The purpose of this research is to explore the nature of caring among the faculty of a community college nursing program in an effort to better understand how they can assist nursing students to become caring professionals.

Background

In September 1993, the Faculty of the North Island College (NIC) Nursing Program will be implementing a new Curriculum. This has implications for the way caring is perceived and incorporated into the nursing program.

Since 1985 the nursing program at NIC has been organized using a curriculum based on behaviorist objectives. Caring is one of the objectives and students are expected to demonstrate behaviors that indicate caring. The theory component which addresses caring in the curriculum comprises approximately nine hours of classroom time in the first two semesters.

The new curriculum, developed by the Collaborative Curriculum partners of University of Victoria, Malaspina College, Camosun College, University College of the Cariboo and Okanagan University College views caring as the "the attitude and activity of nursing and [it] will

be considered in every nursing course..... Caring encompasses moral, ethical, aesthetic, theoretical and practical nursing care" (Collaborative Curriculum, 1992b, p. 10). Caring must be considered by the faculty as a core value (Tanner, 1990) which drives each nursing course.

In the new program where curriculum is defined as the "interactions that take place between and among students, clients, practitioners and teachers with the intent that learning take place"; and where the teachers' awareness of and modeling (Noddings, 1984; Bevis and Watson, 1989) of professional "ways of being and knowing" (Collaborative Curriculum, 1992b, p. 11) are important, instructors may benefit from exploring the concepts to develop a common understanding of their meaning. This exploratory process is especially true of caring where knowledge is identified in the curriculum as both derived from and guiding nursing practice (Collaborative Curriculum, 1992a; Benner and Wrubel, 1989; Benner, 1984), and in a nursing school designed to "support caring and caring individuals" (Noddings, 1984, p.182).

Purpose

As nursing programs begin to include caring as a core value (Tanner, 1990)) "driving" the curriculum, nursing faculty are struggling to make caring content explicit rather then "hidden" or "implicit " as has been and often still is the case. (Bevis and Watson, 1989; Eisner, 1979; Aoki, 1991). In their efforts to do so, nursing

faculty wrestle with difficult issues such as trying to teach a way of being such as caring which is not clearly defined and is personally experienced (Benner and Wrubel, 1989; Benner, 1991; Tanner, 1990; Mangold, 1991). The nursing faculty also juggle the necessity of evaluating caring in students with their knowledge that the reality of what caring is rests within each person's perceptions (Bevis and Watson, 1989; Benner, 1984). They also struggle with the realities of a profession where nurses in practice feel powerless, overworked and undervalued in a patriarchal system, and react by performing only the physical routines of caring, suffering burn-out or leaving the profession (Attridge and Callahan, 1987; Benner and Wrubel, 1989; Noddings, 1984).

Many nursing faculty have received their nursing education in schools where caring was not addressed formally at all or, if so, was taught using a behaviorist curriculum which sought to define and evaluate caring in terms of observable behaviors (Bevis and Watson, 1989). The experiential, contextual, perceptual nature of caring was and often continues to be either ignored or addressed informally in the illegitimate or implicit curricula by instructors who recognize the importance of caring in facilitating health and healing as well as contributing to attachment to the profession (Bevis and Watson, 1989; Eisner. 1979). The nursing program curricula were often devoid of opportunities to explore experiences from a caring perspective, in deference to content aimed at preparing practitioners

proficient in the technical and practical aspects of nursing care (Valentine, 1989; Leininger, 1984; Tanner, 1990).

As a result of the changes to curricula dictated by the emerging emphasis on caring as a core value and their own nursing education histories, faculty feel compelled to assist students to develop as caring professionals but may feel ill-prepared to do so.

The purpose of this study is to explore with my nursing colleagues at North Island College, our individual and collective caring journeys with the intent of developing strategies that will assist nursing students in their development as caring professionals. It is also the intent that the research will be a catalyst to "re-orient, focus and energize the participants" (Lather, 1991, p.68) toward knowing our individual and collective caring reality in order to transform it and enhance the place of caring as a living part of the nursing curriculum (Lather, 1991; Guba and Lincoln, 1989). I am interested in the research questions: How do the nursing faculty individually perceive caring? How did the nursing faculty learn caring? What do the nursing faculty perceive as the contribution their nursing education made to their understanding of caring? What aspects of their experiences in their nursing careers have faculty perceived contributed to or inhibited their caring? How do these perceptions and experiences relate to their responsibilities as faculty required to "teach" caring?

Overview of Research Design

The Associate Dean of Health/Human Service Programs, three full time nursing instructors, myself included, and three part time nursing instructors participated in this research. Aside from three nurses who are employed on a casual basis as relief instructors, this comprises the entire nursing faculty at North Island College. The faculty participated in the research by agreeing to be interviewed individually about their caring journeys. Five faculty members also took part in a workshop designed to explore our caring journeys together and to develop strategies for assisting students to grow as caring professionals.

Through the use of a pre-circulated question guide, semi-structured interviews were conducted designed to encourage exploration of individual caring journeys (Lincoln and Guba, 1985; Lather, 1991; Merriam, 1988). The questions were organized around themes such as, but not restricted to, concepts of caring prior to entering nursing school, experiences of caring as a nursing student, caring experiences in practice, caring experiences in teaching, factors influencing caring and perceptions of particular occasions and paradigm cases (Benner, 1984) that altered their conceptualization of caring.

The instructors then explored their collective perception of caring developed over three years of working together as a nursing

faculty. This was facilitated in a workshop environment where activities were organized in a format determined by the participants, facilitated by a resource person from outside the faculty and designed to provide opportunity to

- become familiar with each other's individual caring histories
- become familiar with "caring occasions" (Watson, 1988, p. 59) that were particularly powerful learning experiences for faculty members
- articulate challenges to caring in clinical practice
- explore our collective caring journey as faculty at North Island College who have been working together several years
- determine strategies for furthering our individual and collective caring knowledge
- determine strategies to assist students in their development as caring professionals including the determination of guides for evaluating students' caring
- develop a document which reflects the voices of the faculty as they have explored caring. The document, this research paper, is an attempt to provide "becoming space where we can think and act with one another into the future in ways that both mark and loosen limits" (Lather, 1991, p.101).

Definition of Terms

Caring journeys refer to the faculty's conceptualization and understanding of caring as informed by their life experiences. A student nurse is any student in any year of the nursing program at North Island College. Nursing faculty includes all the instructors, full-time and part time as well as the Associate Dean of Health/Human Service Programs employed at North Island College. Collaborative Curriculum partners refers to the faculty members of the nursing programs at University of Victoria, Camosun College, Malaspina College, North Island College, Vancouver Community College (Langara Campus), University College of the Cariboo and Okanagan University College.

Limitations

This study is an attempt to explore the caring journeys of seven nursing faculty, myself included, at North Island College. The faculty are white middle class women each of whom has an individual experience of caring. The findings cannot be generalized to other nursing programs or faculties and need to be treated with discretion in deriving curriculum implications.

My role as researcher, faculty member, and research participant poses opportunities for bias which must be recognized where appropriate throughout the study.

Organization of Thesis

This thesis is organized in five chapters. Chapter 1 provides background information, a statement of the purpose of the thesis, an overview of the research design, a definition section, an outline of limitations, and an overview of the thesis organization.

Chapter 2 is a literature review which provides an overview of recent work involving caring. It is organized around the meaning of caring, the teaching and learning of caring, differing perceptions of caring and factors influencing caring in nursing.

Chapter 3 describes the research design and includes a description of the site and the participants; a description of how the caring stories were collected (data collection), how research trustworthiness was addressed, ethical issues, the interview process and the workshop process; and a description of how the caring themes were constructed (data analysis). It concludes by outlining "quality control" (Guba and Lincoln, 1989) measures used in the research.

Chapter 4 contains a discussion of individual faculty's caring themes. It also contains a discussion of themes echoed across the caring journeys and in the caring workshop.

Chapter 5 identifies proposed strategies for assisting students to develop as caring professionals. Interventions which may make possible the implementation of the teaching strategies are also discussed.

CHAPTER 2

Literature Review

The purpose of this literature review is to gain insight into caring through a study of its evolution in the nursing profession, the evolution of how caring has been taught and learned (Beck, 1991) in the nursing profession, and how it is perceived by nursing students, nurses and the public. Reasons for differing perceptions are examined including factors which influence caring and nurses' ability to act in caring ways. While an extensive survey of the literature on caring, curriculum and social issues revealed a plethora of information, this review will be confined to literature which will help to explore caring from the perspectives outlined above.

Meaning of Caring

Concepts of caring in nursing prior to the eighteenth century evolved when "from the beginning of group life nursing care [was] called for because of the helplessness of babies, the infirmities of age, and the constantly recurring exigencies of illness, accident and childbirth" (Stewart, 1943, p. 3). Emphasis in nursing was on the self, on the enrichment of the nurse's own spiritual growth. Duty was more important than client advocacy or treating the client as a whole (Bevis, 1982; Stewart, 1943; Bevis and Watson, 1989).

Nursing care from the eighteenth to mid-twentieth century was based on personal glory, pride in devotion, and knowledge the nurse

had done the best for the patient by performing physician directed treatment. Nursing needs of clients if not ignored were devalued (Bevis, 1982; Stewart, 1943).

After World War II, the articulation of nursing care became embedded in pragmatism. Value in nursing care was based on practical use of nursing skills and the consequences of their implementation for the sick. The focus in care was on the problem or the disability not on the person or family and their wholeness (Bevis, 1982).

As the skills required for competent caring became more obscure with the explosion of technology (Bevis and Watson, 1989), research indicated that "processes and relationships between care giver and care receiver [had] a positive effect on patient recovery "(Valentine, 1989, p. 28). In the 1950's hospitals finally began responding to nursing needs of clients. Value began to shift toward humanism and wholeness (Bevis, 1982; Bevis and Watson, 1989).

Beginning, then, in the mid 1950's, caring in nursing became increasingly defined as embedded in the relationship between care giver and care receiver and was determined by that relationship (Watson, 1988; Bevis and Watson, 1989; Noddings, 1984). Thus, caring and its meaning became "context specific" (Valentine, 1989, p.28) as well as "local, specific and individual" (Benner, 1984, p.209). Today, descriptions of caring in the nursing literature, reflect Noddings' (1984) suggestion that it occurs when "We see the other's reality as a possibility for us, we must act to eliminate the intolerable,

to reduce the pain, to fill the need, to actualize the dream"(p. 14). This suggests that when situations call for nurses to be technically proficient as in the management of a cardiac arrest, the patient feels cared for when nurses exhibit competence in technical skills, and when situations call for expressive actions such as comforting a bereaved family member, this is identified as caring (Benner and Wrubel, 1989). The nurse who accompanies an unconscious critically ill patient on a two hour ambulance ride from a small logging town to a larger treatment center ensuring that the patient's condition remains stable by intervening in a technically competent way, will be perceived by the patient and family as caring. A teen age mom, whose competence in caring for her new baby grows daily as she implements the suggestions gently provided by the community health nurse, has experienced caring .

Attempts by nurses today to define the complex process of caring, in words, are as varied as the stories that they tell to describe it. The British Columbia Institute of Technology School of Nursing definition states: "To care is to feel interest, to feel concern for the safety and well-being of another, to have regard (esteem) for and be interested in the situation of another "(BCIT, 1989b, p. 38) . Benner and Wrubel (1989) define caring by stating that "caring means that persons, events, projects and things *matter* to people" (p.1). Davidson and Ray (1991) describe caring as "the essential nature of nursing manifested through co-presence and love" (p. 83). Mangold in her attempt at a definition describes caring as a "human act that

provides assistance to another which is based on concern and is essential to human survival and health" (p.134). Morse, Solberg, Neander, Bottorff, and Johnson (1991), identify five emerging conceptualizations of care and caring:

1. caring as human science
2. caring as a moral imperative/ideal
3. caring as an affect
4. caring as an interpersonal relationship
5. caring as a nursing intervention (p. 1-14)

To provide direction for the profession of nursing's activities in practice, research, administration and education, in today's varied health care settings, nursing attempts to capture the essence of caring by describing it in many ways. Watson (1988) states:

> Human caring is nursing, therefore, it is not just an emotion, concern, attitude, or benevolent desire. Caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity. Human caring involves values, a will and commitment to care, knowledge, caring actions and consequences (p. 29).

Professional caring "consists of psychological elements (which are affective or cognitive in nature) put into action in an interpretation which is either social or physical in nature" (Valentine, 1989, p. 29). Benner, Tanner, Chesla and Gordon (unpublished data as quoted in Benner, 1991) further add to an understanding of professional caring by describing it

> As the alleviation of vulnerability; the promotion of growth and health; the facilitation of comfort, dignity, or a good and peaceful death; mutual realization; and the

> preservation and extension of human possibilities in a person, a community, a family, a tradition (p.2).

The meaning of caring in nursing has evolved from an early conception of caring for the helpless and infirm as a means of enhancing personal spiritual growth, through a period of emphasis on caring as equated with the effective performance of physician directed practical skills aimed at disease control and cure. The current conception of caring as being embedded in the relationship between the care giver and the cared for, has lead to attempts to define "professional caring" and to stress its importance as the essential nature of nursing.

How is Caring Taught and Learned

> A conscientious first year nursing student was late arriving on the hospital ward. The instructor phoned her at home. The student exclaimed that she had slept through her alarm and would be right there. When she arrived on the ward, she looked pale and was shaking. The student asked the instructor if she was very angry. The instructor replied that she was very happy that the student was OK and was able to come to clinical. The instructor gave her a big hug and told her to take a deep breath before she started her morning work. In a later interview with the instructor, the student stated that she was able to go on and care for her patients effectively that day and had the instructor been angry she would have fallen apart. (E. Burrell, Personal experience, 1991).

Efforts by the nursing profession to assist students to learn caring have changed with changes in society and technology (Bevis and Watson, 1989). Early nursing schools stressed the need to

provide expert physical care (Bevis and Watson, 1989; Stewart, 1943) as a method of caring "about" patients. The student's caring behavior would be analyzed by determining if the student had met the attributes outlined in the curriculum requirements "to be sober, honest, truthful, trustworthy, punctual , quiet, and orderly, cleanly and neat, patient, cheerful and kindly "(Nightingale, 1867, p. 304).

Nursing education in the nineteen thirties and forties stressed that nurses should be prepared not only for the practice of the profession but for life and its manifold home and community duties as well. Assessment of caring would be reflected in how well the student could provide care in the areas of mental hygiene and social hygiene as well as mental disease and similar conditions which lent themselves to preventative and educational measures (Stewart, 1943). The practice of this care was influenced by the adoption of the medical model which focused on disease and its treatment to the exclusion of caring for the whole person. The nursing student would be evaluated on how well physician prescribed procedures were performed. Evaluation of caring, as the basic core of nursing actions (Mangold, 1991), was ignored.

In the 1950's behaviorism became predominant in education, including the education of nurses, and continues to be common in nursing schools today (Bevis and Watson, 1989). This involves the development of "objectives which are stated in a form helpful in guiding teaching and selecting learning experiences and are couched in terms that reflect the changes required in student's behavior"

(Bevis, and Watson 1989, p. 24). As the shift to nursing the whole person began to develop, nursing curricula included objectives outlining caring behaviors. The BCIT Curriculum (1989) contains examples of these objectives for learning caring. The student would be considered to have learned caring if she could :

> describe own feelings about providing nursing care to patients; describe factors, other then feelings, which influence caring behaviors; discuss how own feelings promote or inhibit caring behaviors to patients; discuss how patient's behaviors promote and inhibit caring towards themselves; accept responsibility for own caring and uncaring behaviors towards patients; modify own uncaring behaviors towards patients; demonstrate caring behaviors towards patients (BCIT, 1989a, p. 63).

Recent curriculum developments in nursing programs are reflecting the belief that care is the essence of nursing; "it is a powerful and distinctive attribute of the profession"(Beck, 1991, p. 18)). If the teaching and learning of caring is examined in light of recent work by Noddings (1984 and 1988), and Bevis and Watson (1989), it would be necessary to evaluate not only student interactions with clients but teacher-student interactions as well. The curriculum becomes "the interactions between and among students and teachers with the intent that learning occur" (Bevis and Watson, 1989, p. 5). Caring becomes a reality for students through dialogue and practice, and it is encouraged in students by supporting the development of the intention to be caring in interactions with others (Noddings, 1984; Bevis and Watson, 1989; Friere, 1970). Caring then, becomes a way of being a nurse and it is modeled for students by

teachers. Nursing faculty who model care are vital to student learning of care (Beck, 1991).

TABLE I:EVOLUTION OF CURRICULUM DESIGNS FOR TEACHING CARING
SUMMARY OF CURRICULUM DESIGNS

TEACHING CARING	*EARLIEST CONCEPTIONS- Prior to the 1950's*	*BEHAVIORISM - 1950's to present*	*CARING CURRICULA - 1980's and currently evolving*
CARING - DEFINED	To perform prescribed procedures for physical well being of patients	To exhibit behaviors pre-determined to be demonstrative of caring	The essence of nursing, the core of nursing care
TEACHER	Determines all learning activities	Designs learning to meet objectives, develops learning activities , directs clinical experience	Co-learner, resource, teacher-student, connoisseur
LEARNER	Passive - receiver of knowledge	Passive in classroom. Active in clinical area demonstrates pre-determined caring behaviors	Active - designs learning experiences with teachers to meet perceived needs re caring, co-intentional education
EXPERIENCES	teacher developed, structured.	Chosen to meet objectives	Grounded in teacher/student/ client needs
EVALUATION OF LEARNING	Demonstrates proper techniques as taught by teacher	Demonstrates learning by exhibiting a change in behavior as articulated by pre-determined objectives	Interpreting & Criticizing involving looking, seeing, perceiving and intuiting, rendering, interpreting. judging

Tanner (1990) argues that the student learns caring by experiencing a caring occasion with faculty and that this is possible because "the culture of the school supported enactment of caring

practices " (p. 71). The evaluation of the students' caring in these programs would make use of an interpretive-criticism model involving the teacher and student in a process of looking, seeing, perceiving and intuiting, rendering, interpreting and judging. Experiences would be examined from the perspectives of those involved to evaluate the value or importance of the episode to education, and its significance within the overall scheme of client care and student learning (Bevis and Watson, 1989, p. 286; Noddings, 1984).

The teaching and learning of caring has been related to the historical perception of caring in nursing. Early curricula did not specifically address the issue as separate from acts of care. With increasing awareness of the importance of caring relationships, curricula have moved to recognizing caring as a the central focus of nursing education. Table I, page 17 summarizes the evolution of curriculum approaches to caring as they reflect the evolving perceptions of caring in the profession.

Perceptions and Reasons

> A nurse, who was responsible for administering medications, doing all treatments and coordinating the work of three other nursing staff caring for 20 patients, was talking to a colleague about her frustration at not being able to care for her patients adequately. This became particularly stressful to her when a woman dying of liver cancer said to her "Thank you so much . You are the best nurse here". The nurse explained that she was very upset because in her opinion she could only

> spend enough time with the patient to give her pain medications and change her dressings. The nurse wanted to have more time to be *with* the patient, to listen if she needed it or to just sit by her and hold her hand if that was required. The nurse was appalled that the little she was able to do was perceived as "the best". (E. Burrell, Personal experience, 1986).

The evident tensions in the perceptions of caring noted in the above scenario are representative of those found in research on perceptions of caring by nurses, patients and student nurses.

In a review of studies comparing nurses' and patients' perceptions of caring, Mangold (1991) concluded that there was a "significant difference among nurses' and patients' ranking of most and least important behaviors" (p. 135). The studies suggested that nurses perceived behaviors such as comforting, touching, attentive listening, and sensitivity as effective caring behaviors. Patients were more concerned that nurses demonstrated high degrees of competence in performing hands-on technical skills, physical assessment and monitoring. On the other hand, a study of home care patients (Mangold, 1991) indicated that nurses who cared were those who did "the little things" (p. 135). Parsons (1991), in a study of elderly surgical clients and their families, found that when "patients and families were unhappy with care it was usually related to helping activities rather then technical competence of staff" (p. 145). Patients perceived the neglecting of comfort measures such as the provision of extra pillows as uncaring but were happy with nurses' abilities to use complicated equipment and carry out complex procedures. Watson(1979, as quoted by Komorita, Doehring, and Hirchert, 1991)

found that patients chose "task oriented activities as demonstrating caring, while nurses and nursing students chose affective dimensions of care" (p. 25). Komorita, Doehring, and Hirchert (1991) conclude that two major categories of caring emerged from nursing research on perceptions of caring: "affective nursing skills and technical nursing skills . Nurses conceptualize the [affective care] dimension of nursing while patients perceive the cure and coordination functions as meeting their needs [for caring]" (p. 25).

Komorita, Doehring, and Hirchert (1991) found that nurse educators identified listening to patients as the most important caring behavior. The least important behaviors for nurse educators were those associated with monitoring and follow through. "Patients value activities that represent to be [sic] 'cared for' while nurses place importance on activities that indicate 'care about'. Patients perceived tasks and functions related to the curing dimension of nursing as important, while nurses stressed the process dimensions of care" (p. 28).

Student nurses reported feeling cared for when faculty listen attentively, share their experiences and give students their undivided attention in interactions with them (Beck , 1991). Hughes (1992) found that students described a climate for caring as:

> One in which the faculty acknowledge and actively respond to the feelings of stress and anxiety that are experienced by students, provide opportunity for students to express their opinions and concerns without fear of reprisal, and place high priority on meeting the needs of students. Modeling, dialogue, practice and

> confirmation were described as the faculty-student interactional processes within which a climate of caring is experienced. (p. 63).

Ruehlen(1992) reports that students who persisted in a small community college nursing program felt faculty treated them with respect and caring. Those who withdrew felt faculty treated them with disrespect and felt criticized in an uncaring manner by faculty.

Do the perceptions among patients, nurses and nursing students, reflect a different understanding of caring or a different emphasis or focus in the same process and if so why does this occur? The literature suggests some possible explanations including: the importance of caring not being fully recognized (Gilligan, 1982; Belenky, Clinchy, Goldberger, and Tarule, 1986; Benner and Wrubel, 1989; Benner, 1984; Komorita et al, 1991); "nurses value cognitive aspects of the process of caring while patients cannot be expected to recognize or appreciate these skills ; the cure dimension of caring is most important to patients; the word caring may be interpreted differently by different groups; and finally other variables may include the situation, expectations, and degree or stage of the illness/wellness " (Komorita et al, 1991, p. 28). Tanner (1990) suggests that caring practices may be obscured not only by the use of abstract language but also because caring is often difficult to describe or make explicit. Roberts (1990) describes the "hiddeness" (p. 68) of caring, in that many of its dimensions such as "knowing, being with, doing for, enabling, maintaining belief "(Roberts, 1990, p. 68) are hidden or invisible by their very nature and that the hiddeness does

not reflect the devaluation of caring. Bottorff's (1991) contention that little emphasis has been placed on developing rules and models related to caring may also be a factor in its perception. She also points out that theorists have developed a nurse-focused conceptualization of caring while ignoring patient outcomes of caring. Caring may need improvement and consistency in practice along with definition in terms of patient outcomes to be perceived as helpful by nurses, nursing students and patients.

The varied perceptions of caring are evident in the definitions used to describe it, the curriculum methods used to teach/learn it, and the ways care givers and care receivers experience and explain it.

Factors Influencing Caring in Nursing

> At the nursing station of a medical ward in an acute care hospital of a small rural community, a male medical doctor began shouting loudly, using profane language, and threw a patient's chart across the nursing station about ten feet unto the floor. The nurse in charge had asked him to reorder the patient's narcotics as the previous order had expired one day previously and hospital policy, in compliance with national drug laws, required narcotics to be reordered every seventy two hours. The doctor stated: "This is ridiculous. Why do I need to waste my time doing this? " and then he left the ward. The nurse then explained to the five nursing students and their instructor who were present during the interaction that the doctor knew full well the drug needed to be reordered and she was making sure he "did his job and would not have to be awakened in the middle of the night for an order for pain medication". (E. Burrell, Personal experience, 1990)

"From the earliest times girls and women have been conscripted into nursing by virtue of their homekeeping functions and their sex" (Stewart, 1943, p. 3). Nursing researchers have documented how the development of nursing as a predominantly female profession has had profound effects on nurses' ability to care and to control the environment in which they work, be it nursing practice, nursing administration, nursing education , or nursing research (Benner, 1984; Benner and Wrubel, 1989; Attridge and Callahan, 1987).

Benner (1984) reports that nurses are beginning to recognize that the "very qualities essential to their caring role are the source of their powerlessness in the male-dominated hospital hierarchy" (p. 207). The failure of society, at large, to understand the validity of a feminine perspective on power, has resulted in the devaluing of caring and relatedness. For many women, power is not a win-lose situation but "an expanding renewable resource available through shared endeavor , dialogue and cooperation" (Kreisberg, 1992). Some women tend to define themselves in terms of these "powerful" relationships and often judge themselves in terms of their ability to care. The power in the relationships and in the ability to care has either been assumed, devalued, hidden or perceived as weakness in a society in which maturity is equated with autonomy and power equated with dominance and control (Benner, 1984; Gilligan, 1982; Belenky et al, 1986; Kreisberg, 1992; Ferguson, 1984). Research also indicates that to survive, nurses working in an environment which

values competitiveness, domination and control, often adopt coercive dominating notions of power in the hope that discrimination will cease when they abandon what they value and learn to play power games as men do (Benner, 1984; Kreisberg, 1992; Ferguson, 1984; Bevis and Watson, 1989). "When women do not conform to such norms their work is devalued, trivialized, rendered invisible or controlled in other ways. Both the amount and spheres of knowledge and skills women can acquire have firm boundaries "(Attridge and Callahan, 1987, p. 78-79).

Bevis and Watson (1989) contend that the education of nurses has reinforced the prevailing societal view of power by using a "banking concept" of teaching (Friere, 1970, p. 58) in which students are trained (Bevis and Watson, 1989) to receive knowledge (Belenky et al, 1986) as opposed to independent thinking which, they soon learn, has little value (Tanner, 1990). Tanner (1990) found that even the language used in health care institutions is dehumanizing and detached and students quickly learn this language as they become health care professionals. Patients are admitted, restrained, diagnosed, transferred, released, observed and checked. In discussing incidents of powerlessness, Attridge and Callahan (1987), in their study of Nurses' Perspective of Quality Work Environments, relate a student nurse's experience of feeling required to ignore the emotional needs of patients in order to appear efficient to the clinical instructor. The officially sanctioned, dominant model of nursing education is based on control and conformity of the human mind and

spirit (Bevis and Watson, 1989). Doering (1992) maintains that nursing schools have used examinations, normalizing judgment and hierarchical observation to maintain the dominance of medical knowledge over nursing knowledge . Thus, "those entrusted with caring focus on satisfying the formulated requirements for caretaking and fail to be present in their interactions with the cared-for. Caring disappears and only its illusion remains "(Noddings, 1984, p. 26).

Benner and Wrubel (1989) describe how practicing "nurses daily confront life-threatening situations and complicated treatment regimens that allow little margin for error. The problems are compounded by the lack of authority and recognition commensurate with the life-and-death responsibility of nursing care" (p. 366). Nurses report that they often are unable to control or make decisions over what they perceive as nursing work (Attridge and Callahan, 1987). Doering (1992) states that the tendency to routinize tasks in great detail has stifled initiative and creativity in nursing. Bevis and Watson (1989) note that hospitals and physicians controlled nursing practice until recent times and to a great extent still exercise control of practice. Several researchers report that nurses are the visible and available representatives of a system in which resources are often inadequate, patient care is often superficial and even dangerous. Nurses feel responsible and often guilty for not caring enough even though resource allocation and availability is beyond their control. Because of their closeness to patients nurses are often assigned and accept blame for a set of circumstances over which they have no

control. Without power and methods of managing a system problem, they experience a sense of failure which has a negative impact on their self-worth. (Attridge and Callahan, 1987; Benner, 1984; Benner and Wrubel, 1989). Bevis and Watson report that this oppressive atmosphere lends itself to a tendency to oppress others. Nursing has a continuing tradition of "oppressing its young, thereby socializing a whole new generation of nurses into the system of oppression and control that often perpetuates adaptation to the status quo" (Bevis and Watson, 1989, p. 45) and devalues caring and relatedness.

Attridge and Callahan (1987) found, in their study of nurses' work environments, that the presence of male hospital administrators and the diffusion of masculine notions of organizational control limit the role nurses play in the treatment process (Attridge and Callahan, 1987). In response to increasing demands for cut backs in health care spending, administrators have made ill-advised reductions in nursing staff, nursing salaries have been compressed and pay increases over a clinical career are limited to seven years' worth of increments. Nurses have traditionally been excluded from the hierarchical decision making structure of health care institutions and therefore have little input into the important decisions which affect their lives (Stewart, 1943; Bevis and Watson, 1989; Benner and Wrubel, 1989; Attridge and Callahan , 1987; Doering, 1992). As the profession matures, researchers are reporting the emergence of new models of institutional organizations (Musante, Coleman, and Kneeland, 1992). Nurses can no longer be governed by a system that

renders them powerless in the organization (Musante et al, 1992). Shared governance is increasing in organizations that employ nurses. Nurses must be partners in the management process that impacts their clinical practice (Musante et al, 1992).

Doering (1992) also links the development of scientific knowledge in nursing to the maintenance of the power relationship between medicine and nursing. "The logical positivist/empiricist view, the male model, is assumed to be the human model" (Doering, 1992, p. 31). In the logical positivist/empiricist, view, the world is divided into objective and subjective; there is a clear separation between the knower and the thing to be known. There is only one truth and the aim of science is to come closer to the single absolute truth (Doering, 1992; Watson, 1988; Bevis and Watson, 1989). "The individual is viewed ...as responding to environmental factors in cause-effect patterns, life experiences can be predicted and verified. Once causal relationships are determined, control is possible. Individual perceptions and differences are devalued as the researcher gleans out hard facts of a reality separate from human experience "(Nagle and Mitchell, 1991, p. 18). Researchers note that the adoption of such a view excludes other ways of knowing that are not based on the predominant white middle class male world view but have been identified as "feminine"(Doering, 1992; Nagle and Mitchell, 1991; Bevis and Watson, 1989; Watson, 1988; Belenky et al, 1986; Gilligan, 1982). This view is "philosophically inadequate and inappropriate for professional nursing practice. Neither the realities

of nursing practice nor the complexities of the nurse -patient relationship are reflected in this theoretic stance "(Nagle and Mitchell, 1991, p. 20). Thus research and research methods have only recently begun to address other ways of knowing including intuition and contextual, phenomena-centered knowledge. The goal of this "qualitative research" is understanding and theory generation. "Qualitative methods are non-reductionistic and they attempt to capture patterns of meaning that reflect the human being's experience" (Nagle and Mitchell, 1991, p. 19). Nursing knowledge becomes distinct from, but complementary to, medical knowledge and emphasis is placed on the human to human care transactions between the nurse and person and how that affects health and healing (Nagle and Mitchell, 1991; Watson, 1988; Bevis and Watson, 1989). Davidson and Ray (1991) write "Nurse researchers demonstrate their caring through the problems they choose to investigate and through caring bring the energy that may allow insight into the whole of the phenomena by facilitating harmony, critique and the possibility of a new order" (p. 83).

This review of factors influencing caring has revealed a profession dealing with many issues. These include: issues related to the fact that nursing is a predominantly female profession in a male oriented society: issues related to nurses' ability or inability to make life or death decisions in hierarchical organizations: issues related to lack of resources: and issues related to the way nursing is conceptualized and scientific knowledge about nursing generated.

Summary

Caring, its meaning, how it is perceived, and factors influencing caring have been explored. Findings have indicated an emerging human science of Caring evolving from a profession whose practitioners are predominantly female working within hierarchical structures which are only now beginning to articulate and consciously construct environments conducive to effective caring.

CHAPTER 3

Research Design

This research into faculty perceptions of caring, involving the entire faculty of the nursing program at North Island College, is a qualitative case study. The research fits Merriam's (1988) definition of case studies as "particularistic, descriptive and heuristic [relying] heavily on inductive reasoning in handling multiple data sources" (p. 16). The research is particular in that it is a study of a particular phenomena, caring, and addresses the nursing faculty's perceptions and understanding of caring as they have experienced it in their lives. The research is descriptive in that the experiences of seven people over their life times are explored using individual interviews and a workshop to provide a thick description of caring including their perceptions of caring itself, how they learned caring, and what factors challenged or promoted their caring abilities. The research is heuristic in that the sharing of differing perceptions of caring may bring about the discovery of new meaning for the faculty, individually and together as well as confirming what is already known about caring and its impact on nursing. The research is inductive in that there was no attempt to define caring, a preconceived working hypothesis was not used in the research and the discovery of new relationships, concepts and understanding in relation to caring were explored (Merriam, 1988; Jaeger, 1988).

This chapter provides a detailed description of the research including a short description of North Island College, the nursing program and a general overview of the nursing faculty. Also included are a detailed description of the research design, a description of how caring stories were collected (data collection) and a description of the process of constructing reality (data analysis). The chapter ends with a discussion of the way the research has been attentive to "quality control".

The Setting (Site Description)

Along with giving a general picture of North Island College and the nursing program, the site description also includes reference to college organizational structure. Comments on the organizational structure were felt to be necessary as input into decision making is an aspect of caring discussed by faculty and the faculty's perceptions of the importance of shared decision making will be addressed more fully in Chapters 4 and 5.

North Island College is a community college serving the diverse and far flung population of Vancouver Island north of Bowser, and up to Bella Coola on the mainland. There are campuses located in Courtenay, Campbell River, Port Alberni and Port Hardy with smaller learning centers distributed throughout the region. Although the nursing program will be offered only at the Courtenay Campus as of September 1993, this research was conducted while the program was offered at both the Courtenay and Port Alberni Campuses.

The Courtenay campus has an intake of sixteen nursing students each September. The nursing faculty consists of two full-time instructors and two part-time instructors. The full time instructors teach in the classroom and supervise eight students each in the clinical areas. Although the part time instructors are primarily responsible for supervising eight students in the clinical area, they also have frequent opportunity to teach in the classroom.

The Port Alberni campus has had an intake of eight nursing students each September. The nursing faculty is comprised of one full time instructor and one part time instructor. They are each responsible for classroom teaching and clinical supervision of eight students.

The direct supervision of the nursing program at both sites is the responsibility of the Associate Dean Health/Human Service Programs. She is also a registered nurse, and as such, an integral part of the nursing faculty. She encourages and participates in a shared decision making process with the faculty for issues involving curriculum and nursing program planning.

The organizational structure of North Island College is hierarchical in nature, in that the Associate Dean reports to a Dean who in turn is responsible to the President, who is responsible to the Board of Govenors. Avenues for sharing decision making have been developed by both administration and faculty. Administration spear headed the implementation of a college wide strategic planning process, involving all college staff, in 1991 which resulted in a

Vision Statement, a revised Mission Statement and the formation of several committees involved in work such as program evaluation and program planning. The college faculty voted to form a Professional Association in 1991 and a first collective agreement is now being negotiated.

Who We Are (The Participants)

Deciding how to describe the participants has been difficult due to issues of confidentiality and the naturalistic nature of the research. I considered three strategies for doing this: a) developing a demographic summary table outlining faculty characteristics: b) describing each participant at the beginning of a discussion of the themes constructed from their individual interview transcript: and c) developing individual descriptions to be included here. I have chosen the latter as it provides an opportunity to describe each participant in a holistic way. By being separate from their caring journey stories, the risk of connecting a particular participant to a story is reduced. The names used in these descriptions are pseudonyms. The names used in the caring journeys are also pseudonyms but differ from those used here, another attempt to ensure confidentiality.

Nancy

One of the youngest members of the faculty, Nancy, who identified herself as being between the ages of 31 to 35, has been

teaching in the nursing program at North Island College for four years. She received her basic nursing education in a two year diploma program in Ontario. She graduated as a registered nurse in 1980. Nancy went back to school in 1985 to study full time and received her Baccalaureate Degree in Nursing from the University of Victoria in 1987. She has six years of medical/surgical nursing experience and three years experience nursing in critical care units.

Nancy has taught surgical nursing at North Island College at the Courtenay campus and at the Campbell River campus before that nursing program was amalgamated with the Courtenay program in January 1992. She has also co-ordinated the impending implementation of the Collaborative Curriculum for the past year.

Emily

Although she has been teaching at North Island College for three years, Emily, who is between the ages of 41 to 45, actually has twenty one years of experience teaching nursing students. She graduated from a diploma program in nursing in Manitoba in 1969, received her Baccalaureate Degree in Nursing in 1971 and completed a Master's Degree in Nursing at the University of Manitoba in 1992. Emily also has a Certificate in Adult Education which she completed in 1972. Before becoming a nurse educator, she worked in medical/surgical nursing for six months.

Emily has taught medical and surgical nursing at the North Island College Courtenay Campus, as well as co-ordinating and

teaching a Master Student Course to nursing students. She also developed and taught a course in basic hygiene skills to Human Service Worker Program Students. Emily is currently the Department Chair of the nursing program.

Jean

The Associate Dean of the Health/Human Service Programs, Jean, between the ages of 51 to 55, has been at North Island College for fourteen years. She received her basic nursing education in a hospital school of nursing in British Columbia and graduated in 1962. She also has an Administration Diploma (1964) and an Instructor's Diploma (1984). Jean completed a Master of Education Degree in Administrative Leadership at Simon Fraser University in 1992.

Jean has two years of medical/surgical nursing experience, five years of nursing service administration employment, four years of nursing education administration experience and thirteen years of teaching experience. Her teaching experience includes programs for nursing students, Long Term Care Aides, Early Childhood Education Program students , and Nurse Refresher Program students.

Jean's current position as Associate Dean of Health/Human Service Programs involves supervision and co-ordination of the Nursing Program, the Early Childhood Education Program, the Continuing Care Program, the Human Service Worker Program, First

Aid Programs, and the Prenatal Program. Her office is at the Campbell River Campus.

Norma

Norma, who describes herself as being between the ages of 36 to 40 years, graduated from a diploma program in nursing in Ontario in 1974. She has a certificate in Coronary Care Nursing (1976) and in Operating Room Nursing(1977). She has just received a Baccalaureate Degree in Nursing from the University of Victoria. She accomplished this by working part time at NIC and studying in the Distance Education Program at the University of Victoria.

Norma has two years of critical care nursing experience, nine years of operating room nursing experience at the staff and supervisory level, seven years of emergency room nursing experience and three years of teaching experience.

Norma has taught medical nursing in the nursing program at the Port Alberni Campus of North Island College. She has been part of the nursing faculty for three years.

Rachael

Rachael, graduated from a diploma nursing program in British Columbia in 1980, completed a Health Science Program in Manitoba in 1982 and received her Baccalaureate Degree in Nursing through the Distance Education Program from the University of Victoria in 1992. In fact, she and Norma studied many of their courses together.

She is between the ages of 31 to 35 years, and has taught at North Island College for three years.

Rachael has two years of medical/surgical/pediatric nursing experience, five years of critical care experience, six years of Emergency/Post Anesthetic Recovery/Intensive Care Unit experience, and a total of five years of teaching experience. She also worked for a year doing Paramedicals for an insurance company.

Rachael teaches surgical nursing at North Island College at the Port Alberni Campus. She has also been active on many committees promoting nursing in her community.

Charmaine

Charmaine has been teaching in the nursing program at North Island College for five years. She is between the ages of 36 to 40 and has one year of medical/surgical nursing experience, five and one half years of critical care nursing experience, three months of emergency room nursing experience, and five and one half years of teaching experience.

She received her basic education in nursing in a diploma program in Manitoba and graduated in 1980. One of her instructors in this program was Emily. Charmaine completed, through full time study, a Baccalaureate Degree in Nursing at the University of Victoria in 1987. In fact she and Nancy were classmates. Along with her duties teaching surgical nursing at the North Island College

Courtenay Campus, Charmaine has also been the first president of the North Island College Faculty Association for the past two years.

Janice

Janice, who is between the ages of 41 to 45, graduated from the University of New Brunswick School of Nursing in 1970. She is currently completing a Master of Arts Degree in Education at Simon Fraser University.. She has also completed the course work for the Instructional Diploma Program through Vancouver Community College.

Janice has seven years of medical/surgical nursing experience, two years of nursing experience in a developing country, one year of emergency room experience, five years of obstetrical nursing experience, one year of operating room experience, four years of nursing administration experience and has taught at North Island College for three years.

Janice has taught medical nursing in the nursing program at NIC in both the Courtenay and now discontinued Campbell River Nursign Program. She has also taught a psychogeriatric course for Long Term Care Aides and acted as the Program Co-ordinator Health/Human Service Programs from January to June 1992.

Summary

The research participants obtained their basic nursing education in a variety of ways including a hospital based school of

nursing, community college nursing programs and a generic university based baccalaureate program in nursing. All faculty currently have baccalaureate degrees in nursing. Two faculty have Masters degrees, one in nursing and one in education. One faculty member is currently in the process of completing a Masters of Arts degree. The faculty have nursed in many differing clinical areas and have a variety of practice, educational and administrative experiences. The minimum time any faculty has been at the college is three years and one faculty member has been with the college for fourteen years. These brief sketches of the faculty provide insight into the diversity of educational and nursing experiences that we bring to the nursing program.

Design

Marshall and Rossman (1989) describe the nature of qualitative research as that which

> values participants' perspectives on their worlds and seeks to discover those perspectives, that views inquiry as an interactive process between the researcher and the participants , and that is primarily descriptive and relies on people's words as the primary data (p. 11)

This exploration of caring journeys attempts to pay attention to the characteristics articulated above, thereby, making qualitative research in the form of a case study the research design of choice (Lincoln and Guba, 1985; Merriam, 1988).

Individually and together the nursing faculty have "multiple constructed realities" (Lincoln and Guba, 1985, p. 37) around caring.

These realities can best be studied holistically, and therefore, qualitatively (Bevis and Watson, 1989; Benner, 1984; Collaborative Curriculum, 1992; Lincoln and Guba, 1985; Lather , 1991).

As the inquirer, I am part of the nursing faculty and have an individual concept of caring which influences our collective concept of caring . I cannot be separated from the concept of caring or from the faculty and I am an integral part of the qualitative research process (Lincoln and Guba, 1985; Merriam, 1988; Marshall and Rossman, 1989; Lather, 1991).

The themes, issues and challenges related to caring explored in this research are qualitative in nature in that they may provide others interested in caring with insights into the concept but they are not intended to be generalizable to nursing faculties and students everywhere (Lincoln and Guba, 1985; Hammersley and Atkinson, 1983; Merriam, 1988). The individual and faculty concepts of caring are in a state of "mutual simultaneous shaping" (Lincoln and Guba, 1985, p. 38) through individual and collective ongoing experiences making cause and effect, positivistic, analysis impossible (Lincoln and Guba, 1985).

This inquiry into caring is value-bound, a characteristic of qualitative research (Lincoln and Guba, 1985; Lather, 1991; Merriam, 1988), as evidenced by the following: with the support of the faculty I have chosen the research topic, caring, and will involve the faculty in many aspects of the research process; qualitative research was used in the investigation; collecting stories and constructing

collective caring realities (Lather, 1991; Roth, and Roychoudhury, 1993) was and continues to be influenced by the values of the participants.

The collecting of caring stories through exploring the personal histories of career experiences gained over many years, from my colleagues through the use of interviews and our collective construction of a caring history through a workshop environment, is viewed as a privilege in that the telling of personal and often emotion filled life stories involves the researcher in a relationship of trust and caring. Therefore the usual processes titled data collection and analysis are viewed as and will be referred to as Collecting Stories and Constructing Realities.

Collecting Stories (Data Collection)

> The present is cast against a historical background while at the same time the "naturalness" of social arrangements is challenged so that social actors can see both the constraints and the potential for change in their situations (Lather, 1991, p. 63)
>
> This, in fact, is an assumption fundamental to qualitative research - the participant's perspective on the social phenomenon of interest should unfold as the participant views it, not as the researcher views it (Marshall and Rossman, 1989, p.82).

Through individual interviews and a group workshop, participants described their caring journeys. In preparation for this,

two major issues were addressed - ensuring trustworthiness of the research and paying attention to ethical considerations.

Building Trustworthiness

> It is essential that certain measures be employed during the implementation of the inquiry that either increase the probability that a judgment of trustworthiness will be achieved or that provide the data that will subsequently be needed to reach that judgment (Lincoln and Guba, 1985, p. 281).

Several measures were initiated to assist in ensuring the trustworthiness of this research effort. These included:

- A journal containing field notes was begun in January 1993 and entries were made throughout the research process (Merriam, 1988; Lincoln and Guba, 1985; Guba and Lincoln, 1989). The journal contains research design decisions, personal questions and comments about the research, and documentation of meetings with Advisory Committee members.
- A Supervisory Committee, mandated by Simon Fraser University (SFU, 1992-1993, p. 243), was established. The committee members reviewed and gave feedback about draft chapters of the thesis as they were completed during the research process (Lincoln and Guba, 1985) . The committee members included two professors from the Faculty of Education at Simon Fraser University and the Nursing Research Consultant at the Registered Nurses Association of British Columbia.

- The collection of the caring stories through interviews of the entire faculty and through a workshop provided diversity of sources and methods (Lincoln and Guba, 1985; Merriam, 1988; Marshall and Rossman, 1989).
- The choosing of a site at which the researcher has been employed for three years ensured knowledge of the people and the environment (Lincoln and Guba, 1985).
- There was continuous effort to identify and document biases and distortions (Lincoln and Guba, 1985; Merriam, 1988; Marshall and Rossman, 1989). This was accomplished by providing faculty opportunity to review the materials arising from their interviews as they were developed. This was especially relevant in this situation where I have interacted with the faculty and the college environment for a long period of time.
- The final research document will be reviewed by the external examiner, Dr. Claire Budgen, School of Nursing, Okanagan University College (SFU, 1992-1993; Lincoln and Guba, 1985).

Ethical Considerations

In any research, there are ethical considerations which must be addressed before the actual research begins (Merriam, 1988; Lather, 1991; Marshall and Rossman, 1989; Lincoln and Guba, 1985; SFU, 1992). For purposes of this study, consent was required and obtained from the individual instructors, the Associate Dean of

Health/Human Service Programs and the Dean of Applied Sciences, Trades and Technology.

The process of consent actually began on 8 February 1993 at which time I met with the nursing faculty, outlined the tentative proposal and received there support and commitment to participate in the study.

On 12 February 1993, the Associate Dean indicated her support of the research by agreeing to be a full participant in the study along with the faculty and by offering to request a formal letter of support for the research from the Dean. This letter was received and forwarded to the Simon Fraser University Ethics Committee. The Associate Dean also supported the workshop as a professional development activity for the faculty. On this basis, further planning proceeded.

The process of obtaining consent from the individual instructors and the Associate Dean involved:

- The reading and signing of the Simon Fraser University form "Informed Consent by Subjects to Participate in a Research project or Experiment" at the time of the individual interviews.
- The opportunity to read and retain a document circulated to each participant a minimum of one week prior to their actual interviews. This document outlined the research proposal and the implications of signing the consent form (See Appendix A).

- The opportunity to give verbal consent for the use of a tape recorder to tape the interviews. All participants agreed to the use of the tape recorder. (See Appendix, A)
- The provision of the information that anonymity cannot be absolutely guaranteed, in that records, by law, can be subpoenaed should a case emerge (Lincoln and Guba, 1985).
- The provision of information as to the measures taken to maintain confidentiality and anonymity (Lincoln and Guba, 1985; Merriam, 1988; Marshall and Rossman, 1989; Hammersley and Atkinson, 1983; CNA, 1991; RNABC, 1992b). Anonymity was assured by changing the names of the individual faculty on all documents. A system of codes, maintained separately from the interview transcripts and known only to the researcher, was used to identify the stories and their actual sources. The interviews were analyzed using themes, thereby reducing the likelihood of identification with a particular source. The individuals also had opportunity to read and suggest changes to the materials developed before they become part of the final research document. Faculty were advised that in telling their stories, they should avoid actually naming people and places or use pseudonyms to assure anonymity. Faculty did not choose to have their own names used when given that option. To assure confidentiality, all records, computer discs and audiotapes when not in use, were locked in a drawer in the researcher's residence and will be maintained in a this manner for a

period of five years after the research is complete (Lincoln and Guba, 1985).

Whittaker (1981) notes that the creation of informed consent

> seems to take other things tacitly for granted. These are that the consistency suggested by the original commitment is reliable and will regulate behavior; that definitions and assertions remain pristine and unchanged; that the reality once established will be thenceforth frozen..... Yet all fieldwork is noted for its emergent changing relationships with the people studied, and indeed depends for its success upon this" (p. 444-445).

This is an important consideration especially when the research involves colleagues and the potential sharing of information about interactions between and among each other that were hitherto private. This will necessitate the ethical shaping and negotiation of consent during the course of the study (Whittaker, 1981).

Interviewing

To include each of the faculty in the process of developing individual caring histories, semistructured interviews were conducted. A list of questions was developed as a guide to exploring the issues but during the actual interview "neither the exact wording nor the order of the questions [were] determined ahead of time" (Merriam, 1988, p. 74). The question guide was given to participants prior to the interview so they could think about their caring histories and feel prepared to participate. This format gave the participants an idea of how they could organize their thoughts about caring and

also provided flexibility during the interview by not requiring adherence to structured questions (Merriam, 1988; Lincoln and Guba, 1985; Marshall and Rossman, 1989). A pilot interview with a Community Health Nurse from Vancouver (Lincoln and Guba, 1985) was conducted on 13 February 1993 to ensure the guide was useful in assisting participants to recall their caring journeys. A copy of the guide is contained in Appendix B.

Individual appointments were made with each participant and interviews scheduled at a time and place convenient to the participant. I attempted to ensure that the setting for the interviews was private and free from interruptions (Field Notes, 1993).

The interviews were audiotaped and participants were encouraged to request the tape machine be shut off if they became uncomfortable with the conversation being taped. All participants spoke freely and did not feel it necessary to have the recording stopped at any time (Merriam, 1988; Hammersley and Atkinson, 1983; Lincoln and Guba. 1985). I also kept pen and paper handy in case of mechanical failure of the tape machine and for making additional notes if indicated (Merriam, 1988).

The interviews were transcribed using a wordprocessor as soon as possible after the conclusion of the interview. Details but not the intent of stories contained in the interview transcriptions that could identify individuals were changed with the consent of the participants. The transcriptions and theme constructions were returned to each participant for review to ensure they reflected

accurately what was meant and to provide opportunity for input regarding the themes (Haig-Brown, 1992; Lincoln and Guba, 1985). The participants requested only minor changes to the transcriptions and the thematic constructions. As one participant stated: "That is what I said so it must have been important for me during the interview. I don't want to change it."

To provide a general overview of faculty educational background and nursing experience, a "Demographic Form" was developed (see Appendix C) and completed by each participant.

Workshop

After the interviews were conducted, a one day workshop including five of the faculty, held on 13 May 1993, was organized to facilitate

1. the sharing of caring journeys
2. a discussion of challenges to caring and ways of dealing with them
3. exploration of caring journey that we have experienced together
4. determination of strategies that will assist faculty and students to continue their development as caring professionals
5. development of the research document in a manner which reflects the voices of the faculty as they have experienced this exploration of caring.

To ensure the full participation of those faculty present, including myself, a person outside the faculty, Dr. Celia Haig-Brown, facilitated the proceedings. Her presence at the workshop was important in several ways not the least of which was the fact that she was a woman assisting other women to explore caring, generally perceived to be a "feminine" characteristic (Noddings, 1984; Bevis and Watson, 1989; Gilligan, 1982). She was committed to ensuring all voices were heard and was able to ensure that this happened in the workshop. The fact that she is an educator but not trained as a nurse was important for faculty in that she brought an understanding of educational issues but avoided imposing any preconceived notions of nursing issues. This enhanced the participants ability to pursue their perceptions of caring.

A draft agenda, developed by me and circulated to Dr. Celia Haig-Brown and to each faculty member two weeks prior to the workshop, was reviewed with the understanding that the day would evolve as those attending wished it to but that there were two main items that needed to be addressed. These were

1. that strategies for assisting students to become caring professionals be developed and that these strategies be considered for their application to all nursing courses
2. that the participant's opportunities to participate in the research be reviewed at the end of the day for catalytic validity - "the degree to which the research process re-

orients, focuses, and energizes participants toward knowing reality in order to transform it" (Lather, 1991, p. 68).

The entire workshop was also videotaped with the intent that it be used as a resource in constructing themes and developing strategies. Faculty provided verbal consent to do so and were reassured that the tape could be turned off at any time. They were also assured that videotaped material would not be used in any way other then that outlined above without their specific permission.

The activities of the workshop included:

A. After initial opening remarks and introductions, the faculty worked in pairs sharing particular stories of their choosing from their transcripts with each other. This provided opportunity for the faculty to become aware of the experiences of each other and also to identify "paradigm cases" for possible use in student learning activites. Upon returning to whole group discussion the pairs shared the main points of their discussions with everyone. These points were recorded on flip chart paper and posted around the room for reference during the day.

B. Using a brainstorming technique (Attridge and Callahan, 1987), faculty then considered the following:

Think about our caring development as a faculty. Describe where we have been, where you see us now and where you would like us to be when we start the new program in September 1993.

As the faculty discussed the above, their ideas were written on one of three flip chart sheets as appropriate and posted as well. One sheet

was labeled "Caring- Where we were", another "Caring - Where we are now" and the third "Caring- Where we want to be".

C. As the faculty shared their caring histories and explored their collective caring journey, strategies for assisting students to develop as caring professionals emerged. These were written on flip chart paper and posted around the room.

D. The workshop ended with a roundtable closing exercise and evaluation of the research process as it promoted "catalytic validity" (Lather, 1991).

Constructing Reality (Data Analysis)

> At the outset of a qualitative case study, the investigator knows what the problem is and has defined the case that will be studied in order to address the problem. But the researcher does not know what will be discovered (Merriam, 1988, p. 124).

In constructing the caring realities of the nursing faculty, a system of constant comparison (Lincoln and Guba, 1985) was employed to identify themes emerging from each interview as well as the caring workshop. Shared themes were then constructed. No attempt was made to search for themes that fit preconceived conceptualizations of caring (Merriam, 1988; Lincoln and Guba, 1985; Guba and Lincoln, 1989; Corbin and Strauss, 1990).

Initially themes were constructed from each transcript independent of any other transcript. This ensured that as much as possible the reality of that faculty member in relation to caring was captured. Then themes emerging from the Caring Workshop were

constructed using the flip chart notes and the video recording. After this process, the individual themes were reviewed, workshop themes were reviewed and themes shared by all the participants were then constructed.

Interview Themes

Through a process of constant comparison involving making lists of quotes with similar words and ideas, sorting and resorting the lists, the items in each list became more specific and themes emerged (Merriam, 1988; Beck, 1991). The themes with their accompanying lists were reread and compared with each other to detect areas of overlap or incongruency (Lincoln and Guba, 1985; Merriam, 1988; Marshall and Rossman, 1989). A case in point is Julie MacKay's (a pseudonym) interview. An initial list contained things such as "valued by her parents as a child", "feelings about the man who urinated on her", "dealing with dishonest students", "being helped by the head nurse when her patient died", and "not wanting to deal with ill child". The list was then sorted, resorted and refined until the theme of Caring and Valuing emerged with the sub themes of Valuing Others and Valuing Self. Once the thematic construction was complete, the transcriptions along with a description of the themes were returned to the participants facilitating their input, peer review and contributing to credibility (Lincoln and Guba, 1985; Guba and Lincoln, 1989; Lather, 1991). Minor changes, such as changing a pseudonym, requested by participants' were then incorporated.

This process of thematic construction continued throughout the interviewing phase and was used to construct themes for each of the participant's transcriptions. (Lincoln and Guba, 1985; Lather, 1991).

Once the above process was completed, all transcripts, notes, field notes, working lists and theme constructions were reread. The process of listing, sorting and resorting was again used. The faculty's individual themes were examined, compared, sorted and resorted in relation to each other. Using a process of "inductive reasoning" themes shared by the participants were constructed (Lincoln and Guba, 1985, p. 333). To illustrate how this was done I will describe the process using the shared theme "Caring for others is facilitated when nurses care for themselves". Marnie's theme of "Caring and Self-awareness" encompassed her recognition that in order to effectively care for others she needed to be aware of her own needs, beliefs. and values. Julie describes the same awareness when she stresses the importance of "Caring and Valuing Self". Pat cares for herself and feels comfortable caring when she "fits" into interactions by recognizing her abilities. Tina discusses caring for herself as the only way to ensure true caring for others. Sharon is committed to using her experience to assist her in recognizing the effects of stress on her own caring behavior. Kim sees her caring ability as enhanced when she takes responsibility and cares for herself. I feel caring when I am in control of my own life and care for myself in this way. By examining the transcripts and individual themes, the shared theme was constructed.

Several preliminary shared themes were constructed using the process described above. They were then presented to the faculty in the agenda for the Caring Workshop for input and review.

Workshop Themes

The flip chart papers developed at the Workshop containing the main points of faculty discussion were transcribed using a wordprocessor. The video tape of the workshop and the transcribed flip chart notes were reviewed. Workshop themes were constructed using the process outlined above. A list of strategies suggested by workshop participants was also compiled. Draft shared themes using the individual themes, workshop themes and original shared themes were constructed once again using a process of listing, sorting and resorting.

A letter containing the transcribed flip chart notes of the workshop, the workshop themes, the final draft of the shared themes and a list of strategies for assisting students and faculty in their caring development, was circulated to the entire faculty for review and input. The faculty did not suggest any changes. Following this, the final shared theme construction was complete and the research document was compiled.

Summary

The collecting of the caring stories and the constructing of the caring reality for the nursing faculty, was attentive to "quality

control" (Guba and Lincoln, 1989) in that the process was developed keeping Guba and Lincoln's "Authenticity Criteria" (1989) in mind. These criteria are fairness, ontological authenticity, educative authenticity, catalytic authentic and tactical authenticity. A discussion of how these criteria have been met follows.

Fairness refers to the "extent to which different constructions and their underlying value structures are solicited and honored" (Guba and Lincoln, 1989, p. 247). This has been addressed by ensuring all nursing faculty members and the Associate Dean were involved in the process and could negotiate the construction of the caring reality throughout the research by being interviewed, reviewing transcripts and themes, and participating in the caring workshop.

Ontological authenticity "refers to the extent to which individual respondents own emic constructions are improved, matured, expanded and elaborated" (Guba and Lincoln, 1989, p. 248). It is, "improvement in the individual's (group's) conscious experiencing of the world" (Lincoln and Guba, 1986, as quoted in Guba and Lincoln , 1989, p. 248). The involvement of the faculty in the research through the development of individual and workshop themes and their involvement in the development of strategies for assisting faculty and students in their development as caring professionals, were efforts to ensure the faculty had opportunity to expand their personal constructions of caring. They were also efforts to promote an individual understanding of the role the nursing program will play in

assisting students to become aware of themselves, the faculty and their classmates as caring professionals. The faculty described the research as providing them a valuable opportunity to explore their caring experience. In fact, one participant stated "I see this workshop experience as providing me a whole new perception of how to deal with uncaring situations".

Educative authenticity "represents the extent to which individual respondents' understanding of and appreciation for the construction of others ... are enhanced" (Guba and Lincoln, 1989, p. 248). As noted by Guba and Lincoln (1989) and planned for in this research, the "testimony of the participants" (p. 249) in the interviews and in the workshop attested to the fact that they have attended to and comprehended the constructions of others. Second, at the end of the process the developing understanding and appreciation was seen in the evolving theme analysis, documented in notes, and resulting in the final strategies developed by the faculty (Guba and Lincoln, 1989).

Catalytic authenticity refers to "the extent to which action is stimulated and facilitated by the ...processes" (Guba and Lincoln, 1989, p.249). The research was designed to have the faculty examine current understandings of caring and develop strategies for assisting students to make caring "a driving force" (Collaborative Curriculum, 1992a,), p. 10) in their practice. The actual evaluation of the effectiveness of the strategies will be a task to be undertaken by the

faculty and students in the new program as well as community stakeholders such as patients and clinical agencies.

Tactical authenticity refers to the "degree to which ... participants are empowered to act" (Guba and Lincoln, 1989, p. 250). The evaluation opportunity at the end of the workshop addressed this issue and provided feedback as to the degree participants felt empowered to assist themselves, each other and students in their caring journeys. In fact, four days after the workshop, the faculty were required to attend a meeting with representatives from the Registered Nurses Association of British Columbia Approvals Committee for Schools of Nursing. At this meeting, they answered questions about the new curriculum, about caring and about how the curriculum would ensure the students were being educated to achieve the skills and competencies required of a newly graduated nurse. The Approvals Committee representatives commented specifically on the way the faculty were respectful and caring with each other. They also commented favorably on our understanding of a curriculum we have yet use. Following the meeting, the faculty described their experience together in the Caring Workshop as contributing to their ability to be effective in the meeting.

Guba and Lincoln's (1989) authenticity criteria were used for this research because "It is not appropriate to judge constructivist evaluations by positivistic criteria or standards or vice versa. To each its proper and appropriate set" (p. 251).

CHAPTER 4

Constructing Realities

The task of exploring the faculty's caring journeys has been one that not only expanded my knowledge of other ways of knowing caring but also my knowledge of the nursing faculty as people living caring in the ways that are meaningful to them. This Chapter provides a discussion of each faculty member's individual themes constructed from their individual interviews, a discussion of the workshop themes and finally a discussion of the shared themes.

The faculty have made personal and collective meaning of caring in ways that are in opposition to the prevailing cultural hegemony of extreme individualism, supportive of the independent, autonomous self. Caring is a recognition of our "interdependence and our essential reliance on others" (Benner and Wrubel , 1989, p. 368; Noddings, 1984; Bevis and Watson, 1989). The enormity of this difference in viewing the world is almost immobilizing and feels like a task far beyond what I can address in this research. The faculty's stories are poignant reminders of the struggle and, in many ways, the themes constructed from them will speak for themselves.

Constructing Reality - Individual Caring Journeys

The individual faculty themes are explored by first providing an excerpt quoted from the participant's transcript. The excerpt, selected in consultation with each participant, was chosen on the

basis of being perceived by the participant as being of particular importance in her development as a caring professional. The particular themes of each faculty member's caring reality are then discussed. Although many of the "constructed realities" reflected in individual faculty's interviews, are also reflected in research, the absence of references to the literature is intentional in that I wanted their journeys to be what they are - an individual expression of an understanding of caring.

Marnie's Themes

> As a Head Nurse a most difficult thing for me was to try to deal with a nursing colleague who had been uncaring. I first noticed that this nurse was uncaring when I perceived her continued desire to meet her own needs and to not pay attention to the needs of the other nursing staff on the ward. This nurse didn't care what was going on around her or wasn't helpful to any of the other staff. All that she wanted was to meet her own work-related kinds of needs, or even her needs as a person in terms of having the limelight, in terms of making sure she got assistance without caring about the next person. Not paying attention to other people and what they may require, not facilitating the nursing staff working as a team, doing everything from her own perspective and what it meant to her. She was just rude to other nurses, disrespectful to other people in the hospital, in terms of interrupting, in terms of being inflexible in seeing other people's points of view, those types of behaviors. A good example of this occurred when she requested her vacation at a time when a nurse senior to her had to be off work because of illness. So her vacation had to be postponed. She was upset because of this and made a huge fuss. She didn't show one bit of give in the situation. She was rigid in terms of her needs being met. Now we didn't have a replacement for the nurse who was ill at the time. Anyway, she took it to the Supervisor and when she

didn't get satisfaction she took it to the Director of Nursing. It was just totally inappropriate in that she wasn't taking into account the context of what was occurring. I tried to show her alternate dates for her vacation but it was her lack of flexibility and her way of seeing things very rigidly from her own point of view that was difficult. She was totally off the deep end in terms of her own needs, really agitated. So what happened was, as the Head Nurse, I needed to address this situation. So I did and she wouldn't take any ownership, any responsibility for her actions. She didn't see how there was anything wrong with how she had handled the situation. She was totally demanding and all that kind of thing. I never felt successful, though, in helping her come to some understanding of what was caring and what was uncaring. That's really what I wanted her to come to some understanding about and I honestly don't think I was able to do that. It was such a challenge. It was a challenge, a real challenge. For me to be caring towards her.

I learned from this that caring is being able to be flexible, to be able to put things into context, to see all possibilities in the situation, not being rigid. I felt I was caring in that I felt I needed to help her become aware of when she was uncaring and I had seen lots of potential in her as a nurse to be able to make some changes. I felt I needed to do that for her and for all of us on the ward. I felt that I met her needs in other ways as well. I was able to give her unbiased performance evaluations. I remember sitting down with her and saying to her that she was an excellent nurse but she had some difficulties around this one issue, you know, so I think I was able to see her with potential and I think that is really caring of me. Trying not to be too judgmental although in this case it was very, very difficult for me to do that because she was hurtful to other people although never hurtful to patients just colleagues and to me too. I felt intimidated by her a lot of the time. I felt like I had to be defensive , a lot of the time. If I made a mistake she made sure she pointed it out, those types of things. I expected her to be more reasonable because I was reasonable with her. I didn't expect that she needed to do her work perfectly although she certainly had that expectation of herself and others. But I certainly didn't have that expectation.

> I felt very intimidated, cause she was so strong and so aggressive. But I felt caring because from my point of view I was helping her to come to some understanding about who she was. I was helping her do some self exploration so I felt caring towards her, I honestly did. I didn't like her as a person and I can separate that , because I didn't like her, I really disliked her as a person. I think that I do have a very good ability although I don't not like a person I am able to give them feedback in a very caring way that doesn't threaten self-esteem. I paid attention to her and what her needs were. So I think that I was caring. I think I did try to do the best job I could with her but it is really disappointing because I know I didn't really help. I know she has been uncaring again towards other people, trying to intimidate them. It was a power thing. I must say, she was trying to be powerful over other nursing colleagues. She was trying to gather power on the ward.

The themes of paying attention, awareness and choice occur again and again in Marnie's Caring Journey. Caring for Marnie is a commitment to paying attention to people and situations. By paying attention, awareness of self and others in particular circumstances is facilitated. This, in turn, fosters the choice to be with the other in a caring relationship. Although I will discuss these themes separately, they are in reality, not separate for Marnie but intricately connected in her development as a caring person .

Caring and Paying Attention

For Marnie, paying attention is foundational to her understanding of caring. By paying attention , she becomes aware of self and others. In this way, the caring relationship can begin to develop.

Caring and Being Paid Attention to by others

From personal early experience, Marnie remembers how the actual commitment to being paid attention to by those involved in situations affected her perceptions of caring. She relates how angry and uncared for she felt when teachers were not cognizant of her shyness and self consciousness especially when they called attention to her in a large open classroom with sixty other students and said "Let's watch Marnie turn red". Although the attention was not meant to be derogatory, she still felt "totally uncomfortable and sometimes almost mad". Marnie actually articulates that "teachers didn't pay attention to what was important to me or didn't recognize [the shy] part of me, and were almost mean about it". Marnie also perceives as uncaring a dentist who ignored her fearfulness which caused her to bite down on the drill resulting in a large hole in her tooth. The doctor who denied the possibility of Marnie having sore ankles because he did not have any medical evidence of it, also failed to pay attention to her. Marnie felt uncared for in all these circumstances because as a person she was not paid attention to.

During her experiences as a nurse, Marnie also articulates that she feels uncared for when administrators and colleagues ignore her situation and make decisions which involve her without paying attention to what is important to her. Marnie also feels uncared for when colleagues fail to pay attention to the work she has done in preparation for classes and meetings. In fact Marnie reveals that she has at times became angry in such situations to the point where

she "has been hurtful, in fact extremely hurtful". This a way of being in herself which she finds unacceptable and inexcusable.

This is contrasted sharply by Marnie's experience with an English teacher who went "the extra distance to recognize what [she] had to contribute" and ensured she was part of class discussions in a way that was non-threatening to her and paid attention to her shyness and difficulty sharing in groups. Marnie also perceived as caring, those nursing instructors who made a point of paying attention to her such as an instructor who assisted her in dealing with a busy medical-surgical ward where the nursing staff left much of the work to her. This same instructor paid attention to Marnie when she became ill, had to miss clinical practice and was afraid of failing her semester. She reassured Marnie that all her work would be considered and that as the instructor she had paid attention to Marnie's overall performance and could evaluate her work on that basis.

Marnie's experiences with being paid attention to in different ways, has informed her development as a caring professional. Her feelings of being uncared for are strong in those situations where her beliefs, values and being are ignored. Marnie feels cared for when who she is matters to others and this is a way of caring that she considers desirable for herself.

Caring and Paying Attention to Others

The incidents in her early school years when Marnie remembers acting in ways that ignored the other's realities are painful to her. Marnie describes as "terrible and uncaring" the way a Palestinian boy in her fourth grade classroom was treated. Students "made fun of him because he ate different things, because he even smelled different because of the things he ate at home and the clothing he was wearing was different". She also vividly remembers feeling very concerned, as an eleven year old, for a Jewish boy whom she perceived as being persecuted. She sees these uncaring behaviors as partly a function of not paying attention to the reality of others and being mainly concerned for only personal feelings of worthwhileness. This is also evident in her description of the nursing colleague, in the story related above, who was unable to get the vacation she requested. This colleague was perceived as uncaring because she paid attention to her needs and situation at the expense of those around her. This is also reflected in Marnie's difficulty in being told what to do by others. She describes this as feeling like she is "being controlled with a big stick rather then being paid attention to as a person or having input into what is to be done". This is very irksome as she sees her needs as the one being cared for as being neglected.

When Marnie buddied students with nurses to observe their work and then provided opportunity for the students to debrief

about the experiences, she learned that the students were also aware of the way paying attention to the needs of others was indicative of a caring environment. The students recognized as caring the nurse who made sure a family was paid attention to during the illness of a relative and the nurse who was with a patient by holding her hand.

Marnie, herself, felt caring when she tried to assist her colleague in exploring how her needs for a vacation needed to be put in the context of the larger ward environment. She also paid attention in meetings with colleagues when she was tempted to be angry but instead examined the situation and paid attention to what the reality of the other members might be.

Caring and Paying Attention to Self

Throughout Marnie's story of her caring journey, there is evidence of self-reflection and a concerted effort to pay attention to self. Marnie regretted her participation in the treatment of the Palestinian boy. She was acutely aware of the possibility of persecution and oppression of the Jewish student and in fact became so concerned that her mother and teachers became involved in trying to help her understand the situation. Marnie also examined her "English" Nursing Class's reaction of derision to the "French" section of her nursing class whom she saw as "having a hell of a lot more fun in life than we were". She saw the English students disapproval of the French students singing and playing together as

incongruent with the support she saw the French students giving each other in their shared group activities. She examined her interactions as a fairly new nurse with a woman dying of cancer. The woman had cancer that had spread all over her chest wall and "her whole chest was actually open. It was totally eaten away .....you could actually see her heart beat" . Marnie talked about her inability to pay attention to the patient's need to talk about her situation. She recalls not allowing "her to express how she felt about death, about how she felt about her situation in life"

Marnie stresses that coming to terms with her own beliefs and values has been an important factor in being able to recognize when they tend to interfere with her ability to pay attention to the beliefs and values of others. She uses her commitment to paying attention to self to further her caring relations with others. She explores the effect stress had on her ability to pay attention to individual student needs as a beginning teacher and wonders how significant this same feeling is for the new students. Marnie also points out that when she reacts without paying attention to self and others, she tends to be angry and this leads to resentment and uncaring reactions.

Through her continued efforts to pay attention, Marnie feels she can then "lose her consciousness" and be with others in a more caring way.

Caring and Awareness

It is not the act of paying attention in itself that constitutes a basis for caring for Marnie. This is evident in the uncared for feeling Marnie had when teachers "paid attention" to her without awareness of who she was. It is the awareness of the self and the other that is facilitated by paying attention, that contributes to developing a caring environment.

Awareness of Others

In situations where Marnie perceived that her needs were anticipated and directed the actions of others, she felt cared for. This is revealed in her story about the English teacher who through paying attention to her as a person, became aware of her creative abilities and assisted her in a caring way to participate in class. This awareness of the needs of others is also an important part of the memories Marnie has of a caring nursing instructor. The instructor seemed to anticipate Marnie's concerns. When Marnie was doubting her ability to function on the busy medical-surgical floor, the instructor seemed to sense this and advised her that she was dealing with a more then usual work load and that she should not doubt her abilities. This same instructor eased Marnie's fears about failing a semester because of illness. She also discussed this with Marnie and included her in the decision.

Marnie's own attempts to be aware of the situations of others were rewarding to her in that she felt caring with the nurse who

insisted on meeting her own needs without reference to the wider world. Marnie also reflected further upon this situation and wondered if the nurse was acting from a need for power. Marnie expressed her intention to consider this possibility in similar situations. Marnie's conscious decision to react in meetings to situations with the potential of making her angry, by trying to determine what reality is for the other and to act with that in mind., is a further example of her determination to perceive the reality of the other and pay attention to it.

Awareness of Self

Marnie perceives a nursing instructor's willingness to share her own reactions to living with the pain and debility of arthritis as assisting the students in gaining a beginning understanding of living with such a disease. By paying attention to her own disease process, the instructor was able to enhance the understanding of others. Marnie's recognition of her need to "know it all" as a new instructor and her growing ability to now "go with discussion in class", recognizing that students have a lot to offer, is another instance of her paying attention and becoming aware of her own reactions to situations. She stresses many times that for her it is important to be aware of her own beliefs and values if one is to interact in a caring way with others. In her reflection on her interactions with the woman with cancer, Marnie was able to recognize that for her, the emotional needs of patients have become just as important, and

indeed her ability to meet these needs has improved over time in her nursing career. By paying attention to her growth as a nurse she has understood and acted upon the need to modify her interactions with patients, become more aware of their needs and thus make a choice to relate to them in a caring way.

Caring and Choice

For Marnie, not paying attention and not becoming aware of self and others is choosing not to care. When the doctor chose to ignore Marnie's reality, and thus deny the ankle pain she was suffering, he chose not to pay attention, not to be aware of who Marnie was and thus not to care. When the dentist chose to blame Marnie, the child, for her reaction in biting down on the drill, he chose to ignore her and not to care. When the nurse demanded that her need for vacation be met regardless of the needs of others around her, she chose not to care. When colleagues ignored or forgot to pay attention to Marnie's work prior to meetings, they chose not to care. When staffing schedules are made ignoring the needs of the nurses, then administrators are choosing not to care. When colleagues tell her what to do without taking into account her ability to have input into what is done, they are choosing not to care.

If uncaring is a choice then caring is also a choice for Marnie. She chose to recognize prejudice in her classroom and refrain from taking part in it. She chose as a head nurse, to meet a difficult staff

person in a caring place. She chose to look at other's realities thus preventing herself from acting in an uncaring manner. Caring teachers for Marnie chose to pay attention to who she was and become aware of her needs. They chose to use this information in making experiences meaningful for her. They chose to care.

Conclusion

Marnie perceives her growth as a caring professional as a commitment to paying attention to self and others. In this way she becomes aware of the other's perceptions and then makes a choice to act in the best interest of the other, choosing to meet the other in a caring space.

Kim's Themes

> One thing that I saw as a student that was really uncaring and I still use as an example now about caring was on a surgical ward. There was a woman who had a necrotic abscess on her abdomen that was just draining foul, foul smelling and copious amounts of fluid. She was in a two bed room but they wouldn't put anybody else in the room with her because of the smell. The room was close to the door coming unto [sic] the ward. This was in a big teaching hospital in the city so there were a lot of staff and I remember being in the room with that person and every single person who walked in the door unto that ward made a comment as they were walking unto the ward as to what that horrible smell was. This woman was lying in bed listening to everybody coming unto the ward saying this outside her door. She felt like a leper. She felt terrible. It wasn't until we got an ostomy nurse up and worked with her to apply an ostomy device over the sight to keep [the odor in] instead of just draining into a dressing that it started to get a little bit more under control and then we got every deodorizer, that we could get hold of or every type, you know,

> [of] electronic [device], nil-odor , everything going in that room in an attempt to help her. I remember talking to her about it, how she felt. She didn't want to be a bother to anybody. She didn't want to say anything to the nurses because she felt like she was the outcast of the whole ward. It was my recognition of how she was feeling that caused us to try to deal with the problem. It was me as a student and probably a lot of students might have done the same thing because we had a lot more time with our patients but I happened to have her and that was the first student that she had had so that was me that did that.

Kim's sense of caring arises from her commitment to being responsible for her actions. Responsibility requires decision making with and on behalf of others. Decisions that are made in a caring way are those which respect self and others. She has felt cared for when she perceives her abilities are acknowledged and she is given responsibility which reflects this. She perceives herself as being caring when she considers not only her own needs but also the needs of others as determining factors in the decision making process.

Caring and Responsibility

Responsibility for Kim involves being cognizant of her own abilities and using them appropriately. She also tries to ensure that others with whom she is in contact can take responsibility for their decisions as well, for her this is an important component of caring.

Kim's strong sense of taking responsibility for her own actions is evident in her early stories. She relates being responsible with feeling cared for. She talks about "engineering" her first

hospitalization by convincing the doctor that she should have a cyst on her back removed. She also talked about being able to easily "fool" the nurses doing night rounds into thinking she was asleep. She also remembers seeing members of her family present during her recovery from anesthetic but does not remember that their presence was a great need for her.

The stories that Kim felt important to relate about her caring and her nursing training reflect her sense of being responsible and wanting to be responsible for her own learning and nursing practice. She describes herself as being very astute at finding learning activities for herself and members of her class. She was also proactive in seeking out things to do when she was in clinical such as talking to patients even if they weren't part of her assignment.

Kim's description of the collective action, which she labels rebellious, by her nursing clinical group to put their case forward concerning their feeling that the pediatric instructor "wasn't doing her job", is further evidence of the importance of responsibility to her. The instructor that Kim chooses to describe as having a positive impact on her caring is an obstetrics instructor who recognized Kim's ability to take responsibility and acted on this by recommending her for emergency experience during the preceptorship. Kim describes the students who were chosen to do this as "the most able to work in an area and be responsible for their own actions." Kim also felt caring when she took responsibility to report an intern who

jeopardized patient safety by not washing his hands before examining a patient's surgical wound and when she initiated action to make the woman whose abscess was very foul smelling more comfortable by reducing the spread of the odor.

Kim's experience of nursing education at the University level was different from the diploma training. At the university she perceived students' abilities to accept responsibility were recognized and this was evidenced by the fact that the university atmosphere was freer and the scope was broader. She perceived this as being cared about as a student.

Nurses who gave Kim responsibility were perceived by her as caring. A Phillipino nurse who recognized Kim's abilities and gave her responsibility , cared for Kim. A Director of Nursing of a small hospital who gave Kim responsibility for standard care plans cared for her. A Head Nurse who needed to have her finger into everything and made the staff feel that they their abilities weren't trusted, was perceived as uncaring and a focus of negativity.

In her work as a nursing instructor, Kim felt cared for by the campus director only after he began to recognize that she could handle responsibility and delegated tasks to her. Prior to this she perceived he viewed her as not having "any brains at all". Kim begins to relax in her role as a nursing instructor when she sorts out her responsibilities to students as being able to allow students to "come out being whatever kind of nurse they feel like they need to be".

Issues of responsibility are also important to Kim's perception of caring in her personal life. She sees herself being caring as a parent when she is responsible in promoting her child's independence. She and her husband negotiate responsibility around their roles as parents and being supportive of activities such as Kim's involvement in college affairs.

For Kim, taking responsibility from others is an "uncaring" way to be. When Kim's Mom recognized that she did not have to be responsible for censoring Kim's choices in watching TV., Kim felt cared for. When the staff on a large busy hospital ward trusted each other to do the work and take responsibility they felt cared for. When the head nurse there, treated them as if they could not take responsibility, she was uncaring. The university professor who Kim perceived as acting in a caring way gave the students responsibility for their own learning in class and made it fun. Kim also feels more caring for students when she is able to give the freedom to use their own sense of responsibility in the classroom and in the clinical area.

The necessity of having personal responsibility is very important to Kim's perception of caring. Accepting responsibility for her actions informs her feeling that caring for others is ensuring responsibility remains with them when appropriate.

Caring and Decisions

Kim perceives the decision making process inherent in being responsible as the vehicle for being caring or uncaring in interactions with others. She describes this in an important way. She sees the knowledge of how to be uncaring as a potential weapon that "could be used against somebody". Conversely, decisions which respect self and others are caring and promote mutual need satisfaction.

Kim's early experiences with her family and in the hospital reveal her sense that decisions which affected her could feel caring or uncaring. In recalling early experiences that impacted on her perception of caring, Kim remembers suddenly recognizing that she was no longer spanked by her parents. Her parents' decision, which she tentatively attributes to her own growing up, was important to her. The doctor who responded to her "ouch" when he examined the cyst on her back, made a decision which corresponded to her wishes. When in the hospital, Kim was not impressed with nurses who did not know she was throwing up until they decided to go to the window side of her bed. An action not prompted by their concern for her welfare but by the fact that people were blocking the way to the near side of the bed.

Kim felt her Mom and Dad's decision to turn off the TV when she was watching a show of which they disapproved and walk away from her was uncaring. Her mom's decision to review the situation with her later, acknowledge her error, and apologize was seen by Kim as being an example of how her mother taught her about caring.

As a "farm kid", Kim felt the uncaring in the city kids decision to label her and her friends as "pig farmers".

During her nursing training, Kim remembers many instances of uncaring in terms of how staff looked after patients and she decided to make sure that she would do things differently. Kim develops several strategies for ensuring this happens. She decides to enhance her learning and that of her classmates by finding learning experiences for them. Her decision to join with her classmates in protesting the quality of instruction they were receiving during their clinical experience on pediatrics resulted in presenting their concerns to the director of the nursing program. In deciding to "always keep busy", she found people to talk to and thereby enhanced her opportunities for caring interactions with patients. In deciding to be caring, she saw it as her responsibility to change the environment for the woman who "felt like she was the outcast of the whole ward". Because of this decision, efforts to reduce the smell of the woman's draining abscess were effective thereby reducing the patient's isolation. Kim is also motivated by her decision to act in a caring way when she reports the intern who had decided to be uncaring by failing to wash his hands and treat an operative wound according to the principles of surgical asepsis. Kim's decision to answer a call bell on the maternity ward, even though she was a student and not assigned to the patient, resulted in her assisting a patient in labor to reduce the effects of hyperventilation, coaching her in breathing

techniques and summoning a nurse as delivery appeared imminent. All these caring activities were noted by the obstetrics instructor and resulted in a decision that Kim do a preceptorship on the emergency ward, a clinical experience reserved for those who had demonstrated the ability to cope in that environment.

As her nursing career progressed, Kim's awareness of caring increased. The decision of the director of nursing of a small hospital where Kim first worked, to take a chance on a new graduate, made Kim feel good. The Phillipino nurse who Kim perceived as her mentor and role model, also cared for Kim by deciding to trust her abilities and use them in situations where she felt Kim was more effective such as dealing with a visitor under the influence of alcohol. Kim perceived all the nurses who worked on a busy floor of the large hospital as caring because they decided to work as a team and made decisions about ward routines, shift hours and workloads together. In her decision to "have her finger in everything", the head nurse of the same floor was acting in a way that Kim and the other staff perceived as uncaring because it indicated that she was not trusting them to do their jobs. On the other hand the same head nurse was caring in that her decisions to ensure staff social times were not too disrupted by shift work, facilitated their working as a group.

Kim's decision to return to University also affected her perception of caring. She describes being able to observe a

professor's interactions with her students as beneficial to her growth as a caring professional. Her decision to be part of a study group not only enhanced her opportunities to study but also provided support all the way through the program.

In her work as a beginning teacher, Kim's development as a caring instructor was influenced by a colleague who "lived caring". This colleague made decisions to be with people in a respectful way, to listen to people, and to ensure that people were intact at the end of difficult situations. Kim describes her as a "really good role model". The campus director's decisions to delegate tasks to Kim were also helpful to her. She describes this as being "kind of nice to be seen as somebody who had something to offer". Kim also sees herself becoming more effective and caring as a teacher when she makes" a conscious decision to start stepping back" and letting the students carry on discussions without too much direction from her. She sees her decision to allow students to be more themselves and bring their own experiences to the classroom, as being "a more caring way of approaching them".

The caring required in decision making is important to Kim in her personal life. She sees the decision by herself and her husband to place their relationship ahead of that of their families of origin as being a positive one for everybody. She describes the importance of shared decision making when taking on extra tasks such as being on the executive of college or nursing related organizations.

In describing what she sees as important in assisting students to become caring professionals, Kim sees the necessity of faculty deciding to be caring with each other. She also stresses the benefits of deciding to share experiences with students and allowing students to see that it is permissible to look at personal situations. She sees the faculty's decision to embark on a new curriculum as one in which "our caring travels as a faculty have just begun".

Conclusion

Kim's commitment to caring is expressed in her desire to be responsible for her actions. She also perceives that the decisions necessitated by such responsibility must be made in a caring way that is respectful of others and their abilities to make decisions and be responsible as well.

Pat's Themes

> A couple of incidents really stand out for me as the way I learned about caring. One of them was when I was in training and there was a young girl. She was 16, been knocked off her horse and was brain damaged. That had to be one of the most wonderful caring experiences because her whole life was recreated in her room. We carried out conversations like "Gee it's 9 o'clock in the morning now normally you would be" and "gosh you would be looking forward to seeing your horse at 3 o'clock in the afternoon and go for a ride" . We talked about her brothers and sisters, everything, the whole time we were in the room. She woke up after six weeks and remembered everything. She knew our names. That was probably one of the most pivotal experiences for me and what it truly meant to

care for somebody not just to do the psychomotor things like we were tube feeding her and we were changing her catheter, and we were rolling her, and washing her and all of those things but those were so incidental to what we were able to do with her. Our clinical instructor made sure all this was done and she was wonderful. She had a strong psychiatric background and she talked to us about people. This was an experience that just shone out for me that nursing is a lot more then just getting the skill right. Although I knew that psychomotor skills and those things weren't where I was going to be the best. I think that is probably why when I graduated after I'd worked for a couple of years I was really keen to get into university. I really felt strongly that I had skills I just hadn't found the setting to use them.

I think the other thing that probably had more influence on who I am as a nurse and what I've brought to nursing was the story of a young man, 39 years old, who walked into the unit with his wife. I can still see the room everything, walked in with his little suitcase and he never walked out again. He died within six weeks of leukemia. That was probably one of the most, I know it was the most significant impact on my nursing career. As a head nurse I made a difference. I created for that family in that room their own space. We got a bed for the wife, we arranged for her meals and at that time these weren't things that happened easily. They could never happen before. But we were so committed to making it happen. It was just one of those paradigm cases where you had to do it. Like, we didn't have a choice. They had to have that. They had to have space for his children to come in and feel like home. For that woman who lived there. She lived there with him for those six weeks. What we were able to do and we were able to make a difference, and to me, I think that has always been the benchmark example of how you can do that, how the rules don't count, people do and situations do. That as a staff, if you really want something to happen you can make it happen.

Pat's caring journey is a story of striving for competence and beyond that to expert caring practice. The competence she envisions

is that in which people and things "fit", not into rigid rules but into relationships which enable the creation of "space" in which caring can occur.

Caring and Competence

> "I really felt strongly that I had skills, I just hadn't found the setting to use them"

From the early days of her nursing education up to and including her current practice, Pat has strived for competence and excellence. Her story is one of finding the place for practicing her nursing career where she can use what she perceives as her particular skills.

Caring and Competence and the Early Years

When her mother picked her up from school, took her home, gave her the hot water bottle and tucked her in bed, Pat experienced feelings of being nurtured and cared for during times of illness. Her mom provided expert care. Pat's recognition of illness behavior being rewarded, may also have been recognition of the way in which her mother was able to be*with her* and care competently for her during those times. This understanding is reflected in her experiences at nursing school as well.

Pat's recollections of nursing school stories involve incidents where her performance of psychomotor skills and of being organized was perceived by her as not being the standard she set for herself, not being caring. This is evident in her vivid recall of not recognizing the need to investigate a gynecological patients' pain thereby failing

to note an increase in her temperature indicating a post partum infection. She has feelings of incompetence when she was made to feel very disorganized because she did not have time to soak a diabetic patient's feet until late in the evening. Pat characterizes psychomotor skills and organizational skills as never being her strengths even though she "always got more then satisfactory marks clinically".

The strong feelings of satisfaction Pat received from assisting the 16 year old girl in the story written above, in a manner that not only ensured her physical safety but also looked after her emotional safety, led Pat to the recognition that "nursing is a lot more than just getting the skills right" and she knew that "psychomotor skills and those things weren't where [she] was going to be the best". Her recognition of the incompetence of the nursing student who wrote "crying too damn hard" on the chart of a fussy newborn baby and her feelings of "devastation" at the pain caused to the baby's mother as she read the chart entry, also reinforced her feelings of the "care" required in nursing.

Caring and Competence and Mid-Career Experiences

As she related stories about her nursing career after graduation, Pat's described finding her areas of expertise and competence. Her exposure to First Nation's patients and their families provided opportunity for her to explore her own prejudices.

She had to deal with her own feelings about parents who would "feed their children nicotine" so they would start to throw up then have them admitted to hospital often not returning to pick the children up until several days after they were ready for discharge. She only began to feel good about the care she provided these patients when she gained a beginning understanding of their situation. She gradually felt more competent to assist them in their particular circumstances because of her increased awareness.

During this period of her nursing practice, Pat also defines for herself her area of expertise. She reconciles her feelings of incompetence with "machines" during her care of a patient in the coronary care unit who "was on all these incredible machines". She comes to a personal understanding that it is not machines that make a difference, it is also the nurse herself. This "pivotal point " in her practice enabled her to assert later, as a head nurse that caring for patients was just as important as being "machine" competent when monitors were placed in rooms on her ward before the Intensive Care Unit was ready for occupancy.

Pat's feelings of accomplishment in the story of the 39 year old man of the story opening Pat's themes, and his family are palpable. She knows that she and the unit staff have made a difference and they did it because they "didn't have a choice". Pat and the staff provided expert support for the dying man and his family.

Caring and Competence and Recent Experiences

In her more recent career experiences, Pat continues to emphasize the importance of competent use of self and skills as important components of caring practice. Pat describes as caring students who are prepared, on time, and responsible for completing assignments. She intervenes with an East Indian student who is being required to enter into an arranged marriage by her family, in a way that she perceives as competent in that she "did things with" not for the student by arranging counseling and understanding that the student's decision had to take her family into account as they were her major source of support. Pat describes this as a "critical thing" in her growth as a caring professional. This feeling of competence in interpersonal relationships was reinforced for Pat when a student told her that she was someone that the student could share her feelings with. Pat had confirmation that the goal of approachability she had set for herself early in her teaching career was being realized. Pat has no difficulty identifying the uncaring she feels in situations where she sees people operating with political agendas and forwarding their own interests at the expense of others. She acknowledges that she finds it hard to know what the agendas are and this is a concern. Again Pat is challenged in a situation where she feels inexperienced.

Pat's need to equate caring and competence, motivates her development as a caring professional. Feeling competent increases

her confidence in her ability to make things and situations fit so caring is facilitated between people.

Caring and Fit

The competence which is important to Pat in being a caring nurse enables her to act in a way that allows people and things to "fit" not into rigid rules but into caring relationships. She works on this fit in her personal and professional life.

Caring and Personal Fit

In describing her involvement with a co-operative pre-school movement, Pat also describes her search for a way of parenting that fit for her family. The parenting skills that fit for her and her husband were those that assisted their children to develop their own skills and did not promote their dependency on parents. She describes this way of parenting as caring. She also describes how even the parenting of different children has to fit the child. Her oldest child is very independent and reminds her that "it is OK to be together but it is OK not to be also". The younger child is still "struggling with identity". In making room for their personal and professional lives, Pat and her husband have worked at making both fit and she sees this as caring as well.

Caring and Professional Fit

The feeling of professional fit in nursing was important right from the beginning of Pat's nursing studies. Her description of a supportive, caring relationship with her classmates is one of fit. She describes the relationship as "being supported, people to talk to, people to share experiences with, what [it] was like when you were scared, when you were terrified, when you were having trouble or when things are going well." This professional support group still exists for her today as she and her classmates often meet and still feel cared for as part of that class. Pat also describes a feeling of wanting to be on a male medical ward where "there were a lot of veterans and that was just delightful and so friendly". She had a feeling of "wanting to be there", of fitting in that environment.

In her first teaching position, Pat wanted to fit with the students who were the same age as her. One of her strategies for achieving this was to establish communication with them on a first name basis. This fit for her but it did not necessarily fit with the rules and regulations of the college for as she says "I sometimes used to get into trouble with the director".

Incidents for Pat which she describes as pivotal for her understanding of caring are those in which she not only felt competent but she also felt they fit with who she was. This is evident in the stories of the young girl who recovered consciousness and of the young man dying of leukemia. Pat and the other nurses

ensured the hospital environment was changed to fit these patient's needs.

Another important factor for Pat was her discovery of the Self-care Model of nursing developed by Dorothea Orem. For Pat "it fit so beautifully in putting yourself in other people's shoes". She goes on to describe how easy it is for her to imagine what it may be like to be another person experiencing their situation.

In her discussion of how she feels when students express negative feelings about patients without examining how those feelings will affect their care of patients, Pat wonders how those students will be therapeutic in their interactions. How will they fit, be present with the patient? She solves this by deciding that students need to talk about this and discuss what it will be like for the patient. The question of presencing as being with, or fitting also occurs for Pat in that her current situation requires group work and she sees herself as having a "profound need to be an individual".

Her commitment to being competent and ensuring fit for people and things leads Pat to an even more caring place. She sees the creation of "space' for the caring to occur as an integral part of being a caring person.

Caring and Creating Space

The competence Pat sees as so important in making people and things fit enables the creation of space in which caring can occur.

It is important for Pat that this space is created for herself, her colleagues, students and patients.

Caring and Personal Space

In her personal, as well as professional life, Pat has worked at creating space which enables her to be caring. She does this by negotiating personal and professional space with her family. She also talks about "creating time" for participating in discussions with people such as the psychology instructors at a community college and thus, becoming aware of issues such as "multiple realities" which impact on her ability as a caring person.

In her pursuit of space in which to grow, Pat attended courses at university which she saw as assisting her to find the setting appropriate for the use of her particular skills. Pat also created thinking space for herself when she wrote about caring while at university and was able to discuss with a professor what it meant to her.

Pat's work in the community also created a space where she learned to look at "where the person comes from and where they are going back to". She sees her involvement in the community as instrumental in helping her understand that you have to care for and be present with the whole person.

Caring and Creating Space with Colleagues

When Pat worked with her first class of students, her attempts to create space where the students could approach her, acted in some ways as a limitation to the caring space she developed with her colleagues. Her bending of the rules around forms of address, created a tension and limited the space for caring interaction. This also occurred when she bent the rules to accommodate the young man dying of cancer. Colleagues who had been head nurses for many years had difficulty relating to the changes Pat introduced in caring for this man. They were uncomfortable with the children and his wife having unlimited visiting privileges. They were uncomfortable with the hospital cafeteria providing food for his family. They were uncomfortable creating space for caring to occur.

In her work in groups, Pat wants to create caring space for group decision making, for resource allocation and for dealing with teaching concerns. Pat also feels that the space for caring to occur is limited by personal political agendas and working with this situation is difficult for her in that she often feels hurt. and uncared for.

Caring and Creating Space with Students

As a beginning nursing student, Pat became part of a group. By working closely together, she and her classmates created caring support systems for each other. Pat sees this as a desirable resource for students and wonders how it can be recreated when our students do not have access to residence accommodation, which she sees as

promoting the growth of caring relationships among classmates. She sees as a solution, the possibility of recreating this by promoting sharing of resources, organizing study time and arranging social events together.

As a nursing instructor, Pat sees the creation of a relationship where "people felt they could talk to [her]" as removing barriers to caring. In her own nursing training, Pat perceived instructors who were rigid and rule bound as limiting the space for sharing, as were the conventions of relating to doctors in a manner that was devaluing the contribution of the nurse to the health care system. Her interactions with the East Indian student made space for that student's needs and decisions. Pat's recognizes the fact that reality for student's and instructors may differ and space has to be created for sharing the realities and trying to bring them together or understanding that they have to "stay different". Pat stresses the importance for her of coming from a humanistic perspective and providing space for students to grow and envision what is right for them.

Caring and Creating Space with Patients

Pat's need for seeing that space is created for caring is especially evident in her accounts of interacting with patients. She talks about "recreating" the 16 year old girl's life in her hospital room. She describes how she and the nurses "created a space" for the 39 year old man dying of cancer and his family. She describes

fully her need to create understanding of First Nations issues to facilitate meeting parents in a caring place. It is also evident to Pat when caring space has been limited in relationships with patients. She felt this keenly when the mom of the sick baby read the words "crying too damn much" on the chart. She also recognized how her disorganization was hurtful to a diabetic patient in that she was trying to soak her feet when all the woman wanted to do was go to sleep and how her own needs superseded those of the patient.

Conclusion

Pat's Caring Journey has been, and continues to be, one where she strives for competence and fit. This enables her to create space for caring in her relationships in her personal and professional life.

Julie's Themes

> When I think of caring, it was the people I bumped into, even the teachers I had. I had some wonderfully caring, supportive, people. My first day on wards my patient siezured on me, the very first day. My teacher was Diane Moss (pseudonym) at that time. She never jumped aboard me. She knew I was upset and distressed. She got help from other students and the doctor. This had a large impact on me, cause I even remember the physician's name and I think I was in love with him forever after that. They handled it so smoothly and didn't make me feel like I had done anything wrong. It was a learning experience. I almost wonder if there is something about me that encourages people to project that caring , I don't know . I think back to a death I had of a patient and it was really stressful. The lady died on the bed pan. She had an arrest on the bedpan and then we canceled the [cardiac arrest code call] and Dr. Young(pseudonym) was the physician on that

> night and he stopped me in the hall and talked to me. Jane Gorman, (pseudonym) who was the nurse in charge, took me into the conference room and sat down with me and got me a glass of water and talked me through it. Everybody hated her, why she did that for me and made such a difference to how I felt about that death and how I handled it, I'll never know. They both bent over backwards. I felt anyway. My perception was, to make me feel comfortable with what had happened. My student peers couldn't believe that she had done that because no one wanted to work with her. They just dreaded her and yet she somehow sensed how distressed I was and dealt with it and dealt with it in a way that made me feel better. I don't really recall working with her that much after wards but I would not have supported any negative comments regarding her and indeed spoke up and said what she had done for me. When I compare that to what some of my other classmates felt in the way of support when they had a death, or a critical incident happened, they were worlds apart , worlds apart.

The valuing of self and others along with the recognition of factors that influence that valuing are important components of caring for Julie. Her caring journey is one of feeling personally valued by family, colleagues and students. It is also a story of how she values others and of the cultural, professional and personal influences which she must consider when entering into a caring relationship.

Caring and Valuing

Because she experienced her presence in her family as having value for her family, Julie felt cared for. This sense of personal worth is extended to others, and Julie's caring story is one of

reaffirming the value of others, even in situations where it is difficult to do so.

Caring and Valuing Others

Julie's experience of caring and uncaring is related to her perception of being personally valued or devalued and of seeing others being treated as valuable human beings or otherwise by those around them. From early years, Julie was valued by her family. Her grandmother made her feel special by preparing her favorite dishes. She felt cared for by parents whom she perceived made her the focus of their lives. She was also aware of the uncaring inherent in acts in which others were devalued and humiliated.

As a young child of six, Julie was acutely aware of the injustice done to her young cousin who was denied permission to go to the washroom and consequently "wet his pants in front of the whole class". She knew this to be uncaring and perceived it as the devaluing of him as a human being. She experienced this herself when a nursing instructor in the nursery for new borns failed to recognize Julie's fear of providing physical care for the newborns and wrote a negative comment in her student progress record. This made Julie "mad". She also recognized instructors who yelled at students in front of patients and who "put students down" as not valuing students and not "respecting their space and where they are and what is happening for them".

Julie also felt devalued and uncared for when a man urinated on her in the emergency room and when a woman complained, unjustly, about her to a doctor. Julie perceived a colleague's preferential treatment by a co-ordinator as a devaluing of her as a person. The pressure she felt to take maternity leave and to set a date for returning to work was not applied to the colleague who was also pregnant and a friend of the co-ordinator. When she perceives that she has been uncaring such as in cases of her "mouth speaking before [her] brain has time to register", Julie feels bothered and wants to refrain from reacting in this way.

In contrast to these experiences, Julie also relates how the same teacher who humiliated her cousin was very interested in her and made a special effort to ensure Julie's interest in reading was nurtured. The teacher made special cards for Julie to take home and play school with her younger brothers. She saw this as being valued by that teacher. Nurses who showed an interest in and indeed "broke the rules" by allowing Julie's dad to bring a dog to the hospital to see his mother, were perceived by Julie as valuing both her family and her grandmother. Julie also remembers the doctor who administered the anesthetic when she was having her tonsils removed as being "kind in the way he approached it... He acknowledged what [she] said" and listened to her. Again Julie felt valued and cared for. The head nurse, the doctors and the instructors who helped her deal with her first patient's seizure and

the death of a patient were so caring that Julie wondered if "there is something about me that encourages people to project that caring?"

Julie also remembers vividly caring for a young man who was permanently disabled. She perceives that the nurses were very instrumental in helping him recover in that they "didn't treat him like he was of no value". Julie's tells about how a man who was to have his leg amputated, responded to her request that he sign the informed consent form by saying "If you say it's OK I'll do it". She relates how his trust in her to make the decision about such an operation was overwhelming. He was in jeopardy of consenting to something her did not fully understand. She valued this patient and made sure he received more information about the consequences of having an amputation before signing the consent. This way of being for Julie is also evident in her refusal to carry out a procedure with which she was unfamiliar. She recognized the danger to patients if she attempted to do peritoneal dialysis without ever seen it done or practiced it before hand and valued them too much as people to practice unsafely.

Julie's students also felt valued and cared for. Her recognition of the stress imposed on a student, dealing with her mother's death and trying to complete an assignment, enabled Julie to value and care for the student and remove the assignment requirement. The student expressed her gratefulness for this and felt it as a caring experience. Julie felt she also communicated her care to the student who was having difficulty. Although Julie was honest about the

student's current limitations, she was also honest about her potential and capability. She concludes that she was effective in this situation because the student "felt valued and there were no limitations if she [the student] put her mind to it".

For Julie, the positive experiences of being valued by, and valuing others, have contributed to her growth as a caring professional. For in these experiences, she has perceived the value of others and her own value as well.

Caring and Valuing Self

Although she recognizes that being valued by and valuing others has contributed to her caring abilities, Julie also places importance on valuing her self. She values her ability in bedside nursing which was confirmed as a strength of hers by the fact that she won the bedside nursing award when she graduated from nursing school. This ability is also reinforced by feedback from students who appreciate her role modeling.

For Julie caring for and valuing herself means understanding her own limitations and recognizing that if she is having a bad day that it is "not the end of the world". Julie understands the dilemma inherent in a situation where she wants to cuddle a child who has just bitten her but also wants to protect herself from being hurt. Julie also stresses the importance of faculty valuing themselves and recognizing their limitations. Julie sees that caring for self is as important as caring for others. Julie expresses concern about her

daughter's inability to understand the need to care for herself and make difficult decisions that may be in her best interest but hurtful to others. She sees this as a stressful and frustrating situation. For Julie the "other aspect of caring ..that is really important, is to think about your own space as well".

Factors that Influence Caring

Throughout Julie's story, she details how her efforts to value and care for people are influenced by cultural, professional and personal factors. These are influences which impact on her growth as a nurse and which she considers when entering into a caring relationship.

Caring and Cultural Influences

In her recounting of stories about patients, Julie is aware of cultural influences evident in several cases. As she recounts an incident of being "peed on", the fact that the man was an "Indian off Main Street" is part of the story. Julie doesn't discuss what his being an Indian meant to her but she does acknowledge that "culture does impact and I try to take that into consideration". Although his action was very insulting, she was able to "really care" for him and value him as an individual.

On the occasion of being accused by a patient of not keeping her unit tidy, cultural influences again are a factor in Julie's recall of the story. She particularly mentions that the woman was Jewish.

Despite feeling wrongly accused, Julie recognized that she "didn't like feeling unresolved feelings" and she purposely spent time with the woman discussing the event.

In these two instances, Julie acknowledges that cultural differences have an impact on her caring and valuing. She recognizes this and perceives that through this recognition she is able to provide nursing care in a caring way.

Julie's discomfort, with a situation in which an intern and a woman with diabetes were unable to communicate due to language differences, encouraged her in finding a way for them to talk using an interpreter. Julie's recognition of the frustration and helplessness caused by language differences motivated her to care for both the intern and the woman.

In a different way, culture was also an important part of Julie's nursing education. She remembers having pride in her nursing school promoted by the faculty through a History of Nursing course and through recognition of nursing leaders who were associated with that particular school. This in turn enhanced her caring about her profession and valuing what she learned.

Although not articulated in great detail, Julie's stories give a hint of the complexities of caring for people of different cultures and the challenges these complexities present.

Caring and Professional Influences

Professional factors that influence caring for Julie are those related to the working life of nurses and nursing instructors. These factors range from those which impact on her caring directly and those of the wider world over which she has little control.

In her story about the nurses allowing the dog to be taken to visit her grandmother, Julie relates how she valued the fact that the nurses broke the rules. This was a decision made by those nurses in trying to care for patients in an institution where rules and policies had the potential of interfering with the nurse's ability to care. Julie was also aware of the risks involved in performing the peritoneal dialysis, a skill she had not practiced. She knew that to undertake the task with inadequate preparation was not only unsafe but also uncaring. Julie's reluctance to undertake an "in-charge" position at a small rural hospital was born of not only feeling inadequate to meet the demands should an emergency happen but also of a concern about being "pushed into a circumstance that didn't seem very caring at the time". Julie is able to cope with this situation by evaluating the resources available to her and recognizing that the LPN who is assigned to obstetrics is one with whom she had worked before and whom she "valued and trusted".

The grade school teacher who humiliated Julie's cousin, the nursing instructors who paid more attention to their appearance then to students, and doctors who threw things, were all viewed as

uncaring by Julie. They served as examples of uncaring, a way she did not want to be as a professional nurse.

The nursing instructor who shared stories readily, the nurse who hugged her dying father, and the nurse who massaged her mother-in-law's feet, were important influences on how Julie perceived caring. Those experiences shaped her perception of caring.

Caring and Personal Influences

The personal influences which affected and continue to affect Julie's perception of caring are those related to her personally and those related to the people with whom she comes in contact. Julie described feeling uncared for and not valued when she encountered a school teacher who lacked warmth and a nursing instructor who "didn't engender warmth from the students".

Julie also describes feelings of her own which she has to consider when trying to be in a caring relationship with patients. She finds it difficult to deal with dishonesty. This is evident in her stories about a student who was dishonest about medication administration and the Jewish lady who told her to go on break and then reported her as not "keeping her unit clean".

It is also a challenge for Julie to be caring when her own safety may be in danger. When she encountered, in a psychiatric hospital, a young man who was serving time for murdering several people, and later diagnosed as having a sociopathic personality, she felt spooked. This was a difficult feeling to overcome when she felt obligated to be

caring and to value the individual. This same concern for her personal safety was a factor in her feeling comfortable comforting the little boy who bit her. She wanted to keep her distance but also knew that he needed to be cuddled.

When dealing with patients who required intense care because of their illness, Julie also had to deal with conflicting emotions. When caring for a very ill Oriental child with kidney disease, Julie often wanted to avoid the situation because at times she felt worn to a frazzle. A young man who was paralyzed from the neck down required all her skill in dealing with a patient who was "not a very nice boy" at times. She had to constantly remind herself of the reason for his anger and remember that he needed to be valued for who he was.

In her current practice when dealing with situations that she perceives as unfair, Julie acknowledges that she has trouble with that. This feeling has informed how Julie interacts with students. She initiates measures to ensure she treats students fairly. She spends time each week with a different student, she shares experiences, and she interviews each student weekly.

Julie's own ability to deal with stressful or irritating situations varies with what is happening in her life as well. She makes a conscious effort to recognize this when it is happening. She describes feeling badly when she speaks off the cuff in a nasty way and when she is "short" with her family. Being able to recognize this in herself has also helped her be tolerant of students who are having

a bad day as well. She was able to assist a student identify why her day fell apart and helped the student understand that errors have to be left behind so they do not effect future work.

Experience is also a factor, for Julie, in the development of one's caring abilities. Julie sees that the life situations of nursing students may enhance or hinder their ability to be aware of others and their situations. Julie also describes her own growth as a caring nurse when she recounts the story of the paralyzed young man, and when she remembers the nurse hugging her dad. Julie perceives that these "experiences shape our perception of caring".

Julie feels that the relationship between doctors and nurses is changing. She sees nurses becoming more assertive and seeing themselves as equals in the health care professions. She does acknowledge though, that this is not always the case. She also recognizes that "when nurses are not listened to they feel devalued and not cared for".

Julie expresses concern that the current political climate of restraint is anxiety producing for faculty, students, nurses and patients.. She, herself, worries about opportunities for graduates to find employment. She also sees the impact of the job situation on students in her classes. Julie sees it as important that there be a "conscious effort not to let that impact on how we care for people because people's own space is pretty fragile right now and very difficult".

Conclusion

Julie's commitment to seeing the value in everyone and to recognizing the many factors that influence her caring ability is commitment to caring. She describes caring as a way of being and a very personal thing which for her has been informed by "recognizing the value of every individual and this stems back to some situations [she has] been in where that didn't always occur, sometimes for [herself] but also when others were put down".

Sharon's Themes

> Probably one of the things that has been a real impact on me as a practice person is my own personal experience, life experiences and working experience. Being able to look at patients, looking to see trends in patients. For example, when I was working in critical care, it seemed I got every aneurysm patient that came in and they always did very bad, really bad and one particular incident that really stands out is that one particular fellow had come into the hospital with severe onset of back pain. He had been watching a hockey game or something. He was diagnosed as an aneurysm. They had done an arteriogram on him and found that he the had a huge abdominal aneurysm. They brought him up to the unit where we were trying to stabilize him and they were going to take him to the operating room. Knowing what I knew about the physical aspects of an aneurysm, the size of the aneurysm, and because of the verbal report from the technician, because of the anatomy and surgical procedure, I knew of the difficulties that they were going to have resecting it. I knew this man would not be coming back from the operating room. I knew that he was going to die. I also knew that the family had been waiting in the waiting room for over 2 hours and we were just trying to stabilize him physicality to get him off to the operating room. After we got him sort of half way stable and the OR was ready to come and get him, I wouldn't let him go to

the OR until the family had come in and spent some time with him cause I knew and I think he knew too. He knew it was the last time he would see them. I think maybe the family knew and I really feel that if I hadn't of been an advocate for this patient that his family would have never seen him and that was really important for them and it was important for me. I basically put myself in front of the stretcher so they couldn't take him. That had a real impact. There were lots of things but that tends to really stick out in my mind how important that is. I learned that I was right. He did die on the table. So I knew that I could start trusting my judgment more. I knew that if that was my father I would want to have seen him and talking with his wife after, she really needed to see him too and I think that was really reassuring for me. The other thing is I didn't realize how uncaring the other professionals were. They were just looking after this man's physical needs but I think when you are working in an intensive care setting you forget about the other, you are so worried about the bodily functions that you don't think about how someone is feeling and that has been well documented.

Another incident that really stood out for me was the power of caring. We had an elderly gentleman who came into our ICU that had been very ill. He'd been ill for a long time. He had a pneumonia and heart failure and a heart attack and all those kinds of multi-system failure. He was a tall man. He must have been about six feet tall and he was hooked up to a ventilator and he had all of the invasive things, Swanz-Gantz, foley catheter, aert lines, IV's, everything, you name it. He was old as dirt. I think when you are working in an ICU where you have only one empty bed, you fill it with an 87 year old and then a 24 year old comes in and you have no bed for them, there is lots of ethical issues, then this man was elderly and there were a lot of feelings about whether he should be in the unit or not. Which is a whole different issue in itself. When I looked after him his blood pressure was high, his pulse, everything was way off and he was fighting the ventilator and we were having a really hard time relaxing him. We'd given him morphine, lots and lots and lots of valium and he was just bouncing off the bed. It was really important for me to get him to rest. Well, in tottered his little old wife who was probably

> 87 years old too. I found her a chair, she sat down beside him and held his hand. His BP and pulse came down to a normal range and he fell asleep. To me that was really powerful because I know how important it is but to actually see it on the monitor and to actually see the physical changes in him and how important it was for them to be together. It was just really therapeutic.

Being a nurse is caring for Sharon. Although she doesn't remember caring actually being taught in her nursing school, she perceives it as being learned in an "unstructured way". She describes becoming more caring as she gains experience. Important aspects of caring for her are being available for patients and students as well as being an advocate for people when they need this to further their own health needs.

Caring and Experience

The experiences Sharon has had have informed her idea and practice of caring. She clearly remembers being angry and shocked by the uncaring behavior of a grade school teacher who denied her friend permission to go to the bathroom resulting in her friend being incontinent of stool in front of the whole class. She also remembers "the big fat nurses" who sat at the nursing desk while she and the other volunteer candy stripers answered bells and fed patients. She saw this experience as contributing to her decision to be a nurse and to a way of being a nurse that was going to be different, more caring.

The experiences she had with hospital emergency rooms, where she had treatment for her broken arms, she views as neutral to her decision to enter nursing. She did perceive not being cared

for because the nurses were never around and did not meet her need for pain relief. Sharon also experienced feeling uncared for when nursing instructors and nursing staff were unavailable when she needed help and guidance. Sharon was frustrated and angry at the instructor who appeared only after the woman, who was her first patient, was incontinent of stool. Being left to deal with the transfer of a heavy patient by herself had a strong impact on Sharon as she saw this as being uncaring, in that she and the patient were put at risk.

Positive experiences also contributed to Sharon's conception of caring. She felt cared for by her parents. She recognizes the fact that the decision to have her broken arm repaired under general anesthetic was made by her mom who understood what would be best for them both in that stressful situation.

Sharon also learned about caring from an instructor who was able to "tie everything together" by applying physiology and pathophysiology to patient care needs. The instructor was experienced not only in nursing but also in teaching. Having the care she provided recognized by a young patient, who sent her a card of thanks, was also important to Sharon. This incident led her to explore what she had done for the woman that was caring and she concludes she listened to her. Being asked by older nurses to interact with adolescent patients was important for Sharon in that she felt good about being able to do this and also saw the nurses making an effort to meet the needs of adolescents.

As she continued to practice nursing, Sharon describes her "own personal experiences, life experiences and working experience" as having a real impact on her caring practice. She learned to trust her judgment. This was confirmed for her in the incident where she made a correct assessment that the man with the abdominal aneurysm would not return from surgery. This assessment motivated her to ensure family members talked with him prior to the actual surgery. Her experience enabled her to assess the situation and take action she saw as appropriate to meet the needs of that family. The growth in her experience also enabled her to see trends in patients and to assess their health in ways she used to plan their care and her nursing interventions. It was experience that made her feel confident enough to question a family doctor's judgment of the care of an elderly woman with a subarachnoid hemorrhage. By being able to confirm her assessment with another physician, she felt able to approach the family and help them take further action on behalf of the woman by suggesting that a transfer to a larger center may be appropriate. Her experience in the Intensive Care Unit has demonstrated for her the power of caring as she describes so vividly in the story of the elderly man who was immediately comforted by his wife. As she gained more experience, she was able to modify her behavior in patients' interest. This was the case when she learned to discount the opinions of a "burntout" nurse who perceived all young people as drug abusers. Sharon's initial acceptance of the nurse's belief had to be modified after she

recognized that this opinion had interfered with her caring of a young man with cancer by making him wait unnecessarily for twenty minutes for a pain reliever.

As she has become more experienced, Sharon has been able to shift the focus of her practice from the physical to include emotional aspects of the patients as well. She describes her teaching experience as contributing to this. She can look at people and be more aware of their non-verbal messages. This increased awareness of a holistic approach to patient's needs enables her to see the caring involved in providing mastectomy clients with extra padding for their wound dressings. It is also this experience that informed her decision to choose to postpone processing a doctor's orders in favor of teaching men who were ready to learn about their experience with a heart attack even in the face of pressure from the other staff to get the orders done.

Experience in recognizing the effects of stress, such as the stress related to being hungry, tired or mentally preoccupied with personal problems on her own caring behavior, has informed her interactions with students having problems. She assists them to assess their own situations and make decisions for improving their nursing care by ensuring their own needs are met as well.

As she has gained experience, Sharon has become more confident of her caring ability. She can assess all the needs of patients and sees herself being more available to meet these needs.

Caring and Being Available

For Sharon caring and being available have been associated in her mind her for a long time. When people are available for her she feels cared for, and when they are not available she feels uncared for and alone. She sees being available as an important role for her as a nurse and a teacher.

Sharon describes herself as a child as better off then a lot of kids, because her mom "was always there in the house when [she] walked in". She also describes not understanding the importance of this until the few times her mom was unavailable. The teacher who was angry at the little girl for soiling her pants was also unavailable for that child and in fact was angry at her. Although she sees her emergency room experiences as a child as neutral in her decision to be a nurse, she remembers that the nurses were never around, they were not available. As a Candy Striper, Sharon also saw the nurses as unavailable to the patients and she was determined not to be like that as a nurse.

Some of Sharon's most vivid memories of nursing school are of being left alone to deal with situations which she felt compromised safety for her and the patient and were, therefore, uncaring. Her feeling of abandonment is palpable in the story of her first clinical day. Her inability to communicate with her patient who could not speak and needed the bedpan resulted in an embarrassing situation for both of them. The patient was incontinent of stool in her bed. It led Sharon to wonder where the instructor was when she, and the

patient, needed her. This is also true of her feeling of being thrown into clinical experience with no help. Her need to get things done as a student, leads to her caring for people such as the transferring a heavy patient by herself, in an unsafe and uncaring action. The instructors were unavailable. This feeling of not having her need for assistance met as a student, led Sharon, after graduating, to discuss it with other nurses. She learned that it was a common experience, that "you do something once and then they are gone. You never see them again".

Sharon's experiences as a new grad also reflect her feeling of caring as "being available". She describes her early practice as concentrating on understanding the medications, learning the theory but not spending much time looking at the patient, not picking up on the non-verbal cues. Her perceived necessity to get the psychomotor skills correct rendered her unavailable to meet the other needs of patients. Her availability as a young graduate nurse to talk to adolescents made her feel good even though she attributes her effectiveness in these situations to her age not to her ability to communicate.

As her career in nursing has progressed, Sharon has cared for patients by being available in many ways. She was available to literally throw herself in front of the stretcher so the family of the patient with the abdominal aneurysm had opportunity to talk with him. She was available to ensure the elderly man's wife could sit with him anytime she wanted. She was available when a family

needed to make the decision to send their elderly relative to another hospital in order to treat a subarachnoid hemorrhage. She was available to teach heart attack patients in ICU when they were ready to learn. She saw a nurse suffering "burnout" as unavailable to assist patients non-judgementally and almost fell into this way of being herself. Sharon also recognized the need of a woman hospitalized for an ectopic pregnancy, to have the one nurse on the ward who was pregnant available to assist her. Sharon saw that nurses needed to be available in another way for a woman who had terminal cancer and was pregnant. She needed nurses to respect her decision to try to deal with cancer pain without drugs for fear of harming her baby and be available to assist her in a manner she chose, not in a manner they decided was best for her.

Sharon sees being available and approachable as an important part of her being caring as a nursing instructor. She remembers as caring an instructor who was approachable and who seemed warm. She feels that if students are not comfortable coming to her with problems then they will go to someone else and that is not always appropriate. She does not want to be perceived as an "unapproachable bitch". She also appreciates the input of other faculty and staff nurses when she is making difficult decisions about student progress. She defines the caring that she sees her current students exhibiting for each other as being available to celebrate and console as required.

In being experienced and available, Sharon meets her patients and students in a more caring place and can then expand her role to be an advocate as well.

Caring and Being an Advocate

It has not been enough for Sharon to be skilled and available for people to consider herself caring. She also needs to be an advocate for them in situations where their ability to do so is compromised.

In her story about the man with the abdominal aneurysm, Sharon describes her need to have the family talk with him as an imperative one. She literally throws herself in the way to make sure this happens. She feels that "If [she] hadn't been an advocate for this patient that his family would have never seen him and that was really important for them and for [her]."

The impact of the elderly woman's presence on her husband's physical being became, for Sharon, a paradigm case. After this experience she became an advocate for the presence of families in ICU's even in conditions where it may have required major adjustments on the part of health care personnel.

Sharon's willingness to suffer the negative feedback from nursing colleagues, in order to teach the men about heart attacks, was an act of advocacy for being with the patients when required. This is also true of her defiance of rules and regulations in the case of the elderly woman with the subarachnoid hemorrhage who she

perceived required more advanced care than the local hospital was able to provide. Sharon was willing to risk being fired from the hospital in order to give the family the option of approaching the family doctor and having the care of their relative reviewed and revised in her favor.

In understanding the need for the woman terminally ill of cancer to refuse pain medication because she was pregnant, Sharon and the other nurses were advocates for her right of choice. This was difficult for the nurses because their experience told them the choice would be a hard one for the woman to cope with. Often these issues are not only difficult personal ones but also become ethical in nature. Such is the situation for Sharon in the case of suicide victims. Advocacy for these patients is not a clear cut decision. This often leads the nurse to act in a way the patient will perceive as uncaring.

Sharon sees her role as a caring instructor as one of advocacy. She describes the need to help students meet their needs. She sees a need to teach in ways that recognize student differences. She was an advocate for a First Nations student in that she adjusted the program to meet her needs for oral learning rather then book based learning and arranged for a tutor for her.

Conclusion

In becoming experienced as a nurse, Sharon perceives that she is caring. This caring involves being available and advocating for people who require these caring activities in order to meet their

health care needs. She also sees these caring ways of being as important in assisting students to become caring professionals.

Tina's Themes

What I was most angry about in nursing school was that I never learned how to deal with death, I never learned how to take care of myself, I never learned to be self-aware. That is one thing that when I realized that I really had trouble with things, I thought well that should have been taught in nursing. That is why with the new curriculum, why I think that is so important because without the self-awareness, you can't really care. Even though I may have been taking care of people before, I never really was caring because I didn't know how to care for myself. At that time I would take my problems home, and finally I started taking drugs and things like that. I couldn't bear the pain that I felt and I didn't know how to deal with it. I didn't want to drink because people could smell it but drugs were easily accessible for me. I started out with migraine headaches with that and it just swelled as the pain got harder and harder especially dealing with the family. I medicated the pain rather the looking at it. I would think that that is what I learned, when I finally quit taking drugs and learned about myself and self-awareness and learning about how my dad didn't give us the unconditional love, that I had to give myself that and I had to give those people around me that. I became self-aware through intense therapy. I went to a psychologist who was the most helpful. There was a counselor here in town I went to but a psychologist, she just said "Start talking about your life. Tell me what it was like growing up in your family" and then from that she would just say "Well what does that make you feel like?" I began to learn about my feelings and get in touch with my feelings and things that I thought were OK and when I discussed them with her she said "Do you really think they were OK? Were they really accepting you as a person?" So I had to go back through all of that. What I had to do was take apart Tina as I knew her and start from nothing. Because everything in my life didn't make sense. It was there but I couldn't put it all together. I had to take it all

> apart and build it after that. Actually this happened 8 years after I became a nurse. What probably spurred it on was I took my nursing in Toronto and I worked there for 8 years and you could always do a really good job, like you worked in intensive care and you worked in the operating room and everything was fine. You did a really good job but you never saw those people again. You didn't know what the family was like, you didn't know what impact it had on everyone concerned. Then I came to this town where I know people, where I have family, where I have lots of friends and I worked in emergency and in the OR. All I saw was people's pain and I didn't know how to deal with that. But I didn't really see that common thread of why it was different here but I knew that it was different and I knew I wasn't handling it well. In the same year my brother was diagnosed, my dad died and my mom died shortly before that. I was in an abusive marriage which many nurses do and so all of those things together pile up and I was taking it all home with me. It was too much for me.

In caring for herself, Tina becomes more self-aware. In doing so, she perceives she can then respect others and their choices . This for Tina is true caring, unconditional acceptance of self and others.

Caring for Self

Until she learned to love herself, Tina describes her nursing as caring *for* people not truly *caring about* them. She understands her early nursing work in this way. She relates this to the fact that her own identity went into "early closure" and she saw herself as others did, a good girl, a hero. As she was faced with death, looking after herself and looking at herself critically, she became angry with her nursing training in that it neglected to address these issues.

Tina sees her growth as a caring professional in conjunction with her growth as a self aware individual. This growth was not facilitated by her nursing training but by her as she dealt with behaviors, which she defines as self-destructive, and related to dealing with pain in harmful ways, such as medicating it instead of looking at it. The pain of wrapping a shroud around a dead woman's body only days after she had buried her mother; the pain of working over Christmas with a sore neck while in mourning for her brother who had passed away only a few weeks previously; the pain of an abusive marriage; and the pain of bearing the hurt of others, required attention. She worries about a new nursing program in which students and faculty will be required to share and explore similar pain in their efforts to become more caring. She sees her willingness to share some of her experiences with pain and her exploration of self as role modeling for students a way of paying attention to the pain which may result in a positive outcome for them as it did for her.

In her search for self awareness, Tina learned that caring for herself was essential if she was to truly care for others. She did this by accessing a counselor who assisted her to explore her past and continues to assist her during stressful times. She also ensures she takes time out for self reflection. She gives herself unconditional "self-love". She believes in a "Higher Power" and sees God as directing what is meant to be for her. She chooses to work in environments where she feels most able to meet her needs for she

feels that unless she can meet her own needs she cannot meet the needs of others. This is evidenced by her decision in her early career days to work in ICU with a few patients where she felt able to care for the whole person rather than working on a ward of many people where her personal resources for being with others would be limited.

For Tina "the difference in *caring* and *caring for* is you are truly caring because you are taking care of yourself first. It isn't psychologically draining like it is the other way. You can let go."

Caring and Respect

As the stretcher she was on was being shifted about by hospital staff as if she wasn't even there, Tina, who was dealing with the physical and emotional pain of an ectopic pregnancy, felt very uncared for and disrespected. The nurse, who touched her hand and moved her into a quiet corner, respected Tina as a person and, in this very small way, conveyed caring. Tina sees the challenge of having enough time to truly care as surmountable in small respectful, caring acts such as this. This is reinforced for her by the fact that many people undergoing surgery tell her afterwards how caring they felt just by looking in her eyes. Tina's experience of being respected as a person has informed her striving to be respectful of others. She remembers vividly the woman who asked her "Tina, how can you do this to yourself, you are such a good person?" . She saw this as more helpful and respectful them any derogatory remark and uses the

memory of it to guide her in her interactions with her students and her family.

Tina's commitment to seeing the positive in everyone is evident in her story of having to council a student out of the nursing program. Tina feels that the student left feeling good about herself and this was confirmed for her by the student's gift of flowers.

Tina uses this attitude of respect to assist students in their growth as caring professionals. She tries not to tell students things but encourages self-exploration by "planting seeds" and suggesting ways of looking at things which reflect seeing the world through the eyes of patients. The effectiveness of this has been demonstrated for Tina in that her sharing of life stories is reciprocated by students. Students have approached her with problems such as bulimia, destructive teenagers and other life stressors that interfere with their effective caring. Tina sees herself assisting students to explore these issues and, by this, learning what true caring is, a growing process which she feels never ends.

Caring and Choices

In caring for and respecting herself and others Tina is able to accept her choices and the choices of others. She recognized this as caring even at a young age, when she felt that an aspect of her mother's unconditional love was her ability to allow her children to make their own choices. She saw her father's need to control her choices as revealing his inability to love her unconditionally, a way

of being Tina equates with true caring. Tina tries to care in this way with her family. She feels badly when she tells her sister what to do during her brother-in-law's funeral. She sees that as not allowing her sister the choice to feel as she needs to, not as Tina tells her to. She also recognizes her love for her brother who "drinks too much" and sees that as his choice.

By making her own choices, Tina feels she learned "a lot of [her] own lessons". She sees part of this as making a choice to have time out for herself when stress adds up, a challenge to her caring ability. If she is feeling empty herself, then she has little to offer others. Recently, Tina finished studying for her baccalaureate degree while continuing to teach. She sees these choices as number one in her life and recognizes the completion of her course of studies as affecting her choices again. She states "Now that I have finished my courses I can go back to caring for my other kinds of growth."

She also sees choice as an important aspect of caring for others, "You can let other people make their own choices and that is caring to me". Even though other's choices may not be what she would like for her life, she is able to see this as putting health care back where it belongs, with each person. as they choose to be. She explores the fact that although their own choices may be painful to them personally, there cannot be total freedom from pain and people learn from pain.

Students also learn from making choices. The student who failed out of nursing, had to make a difficult choice but she was able to thank Tina for her assistance in this matter and send the flowers. Tina also encourages students to explore choices in caring for people and asks them to "sit in the other person's seat". Tina also explores the necessity for instructors to choose to "walk the walk" not just "talk the talk" in relation to caring for themselves and others. Tina feels that not requiring students to do journals, shortening classes or canceling classes, as choices not to care and a message students will easily perceive.

Conclusion

In her journey of self discovery, Tina has decided that caring for herself enables caring and respect for others . This true unconditional caring facilitates acceptance of others and their choices.

Constructing Reality - Caring Workshop Themes and Shared Themes

Visits to the Same Places

Although each of the faculty have individual experiences and perceptions of caring, there are also connections, trips to the same places, evident across the caring journeys. Reflection upon the

shared themes arising from the individual participant themes and the Caring Workshop themes provide a path for the development of strategies to assist students in their caring journeys.

CARING WORKSHOP THEMES

The opportunity to share caring stories at the workshop was also an opportunity to discover how perceptions about caring were shared or differed. The video tape of the workshop and the flip chart notes were reviewed and themes were constructed once again using a process of listing, sorting and resorting. The themes that emerged reflected the themes of individual faculty. The themes are numbered not to indicate a difference in level of importance but for ease of reference. Again I have declined to include references to the literature in that I wanted the faculty's collective understanding of caring to be expressed from their perspective.

Workshop Theme 1: *Caring involves being sensitive to people.*

During the workshop, the faculty, in small group and whole group discussions, became aware that their stories reflected a recognition that being sensitive to people, as a component of caring, was a shared perception. The stories they chose from their transcripts and other stories they chose to share are evidence of this perception.

Faculty related instances of feeling uncared for when they were treated with insensitivity. Kim shared the story from her

transcript of feeling uncared for at her employment interview with the Assistant Director of the College Center. He was cold and insensitive to her as a prospective employee. Julie related how the head nurse and the doctor were sensitive to her feelings when the patient assigned to her had a cardiac arrest on the bed pan. She felt cared for. Julie also described how a colleague of hers has never been able to deal effectively with death. She felt this may have been so because as a new grad she was required to stay after the end of her shift to care for the body of a patient who had died. This was her first experience with death and the supervisor said to her "Well I suppose you will be asking for more pay for this".

The feeling of caring in situations where the faculty felt that the other was sensitive to their needs is very clear to them. It is also very clear to them that insensitivity is uncaring and ignores the reality of the cared for.

Workshop Theme 2: *Caring involves valuing people.*

Many of the stories contained in the individual interviews which faculty shared with each other in the workshop stressed the relationship of valuing and caring. The faculty's discussions in this area echoed many of the individual themes.

Marnie's feeling of being devalued as a person when two teachers in her large open Grade Seven classroom pointed her out and said "Let's watch Marnie turn red", prompted Julie to share the story of her cousin in Grade One being denied permission to go to

the washroom and as a consequence was incontinent of urine in front of the whole class. These stories are similar to one in Sharon's interview where she remembers her friend being denied permission to go to the washroom and being incontinent of stool in the classroom. The recognition of the devaluing of persons has an important impact on shaping a commitment to caring as valuing.

The importance of valuing to caring was also evident in the faculty's descriptions of our caring history. They expressed how lacking input into decisions affecting their work life made them feel uncared for and devalued as employees. They perceived that the status of being a "sessional" employee over many years was not only stress producing but also demonstrated a devaluation of them as individuals. The faculty also described how this atmosphere is changing in that a first collective agreement is being negotiated, regularization of employees is included in the negotiations and that the college has initiated a strategic planing process involving employees at all levels. The faculty also recognized that within the nursing faculty, itself, our abilities have been valued by the Associate Dean who has supported and participated in our collaborative decision making efforts. A hoped for future is to see all employees at the college valued and cared about by the implementation of shared governance college wide.

Workshop Theme 3: *Caring is understood from experiencing and recognizing the positive and the negative.*

The stories related by the faculty at the workshop, reiterated their individual recognition that they learned caring from being part of or observing caring and uncaring occasions. As a group they discussed the importance of remembering this when working with students.

Marnie described how nurses are often "instrumental in patients not having a good outcome" and this often has a life long impact on their perceptions of caring. Pat described how she felt responsible for the death of a patient who died twenty minutes after she administered morphine. I described how my decision to leave an inexperienced nursing aid in charge in the labor and delivery ward resulted in the death of baby boy. The baby boy was desperately desired by his family and they ascribed his death to the fact that a curse had been placed on them. Kim's positive feeling of making a difference in the hospitalization of the woman with the foul smelling draining abscess, shaped her future commitment to making a difference for people and caring in this way.

These experiences were seen by the faculty as shared by many nurses. They are experiences often not discussed but powerfully shaping a commitment to caring.

Workshop Theme 4: *Caring is being respectful of cultural differences.*

Although cultural influences on caring were discussed in terms of valuing others and of being aware of others, in the individual interviews, the faculty perceived that a commitment to respecting cultural differences was also a commitment to caring.

Marnie shared her story from her interview transcript of the harassment she perceived her elementary school mates visited upon a Palestinian boy in her class. She perceived this as uncaring and ascribed her classmates actions to "maybe needing to feel powerful" . Julie shared how her caring journey transcript revealed her commitment to recognizing the impact culture has on caring. She went on to describe how in her small "WASP" hometown, a male, black teacher from Bermuda, had to work hard at being accepted as a teacher and not perceived as someone who was being sexually inappropriate with female high school students. Celia also shared a story that powerfully demonstrated lack of caring as a result of cultural differences. She described how the land where North Island College now sits was originally part of an Indian Reservation and was donated by the First Nations People to the town for the building of an elementary school. The chief did not want his daughter to have to go to residential school. The day the school opened, the chief took his daughter to be enrolled and they were turned away.

The commitment to considering how attitudes may affect the ability to care, when cultural differences are involved, was seen to be

an important issue to address in the new curriculum. The faculty expressed their concern that course content reflect this commitment.

Workshop Theme 5: *Caring for self is as important as, if not foundational to, caring effectively for others.*

The importance of caring for self, a theme expressed in individual ways in each of the interviews, was important to the group's understanding of caring as well. The faculty perceived caring for self as pertaining to individuals as well as to the faculty as a group and to the students as a group.

Kim described how caring for herself means being with her young son and her husband. She did not want this to be perceived as being uncommitted to the new caring curriculum but as an important part of her life right now. Julie also commented that being with her family was caring for herself and gave her energy to be caring with others. I described how caring for myself meant using my high energy level at work and was I fearful that this was at times perceived by others as a judgment that they were not doing enough.

The faculty's desire to be involved in decision making, to be assured of their teaching positions by regularization, and to pursue shared governance, reflect their feeling that caring for self enables caring for others. They also see this as adding to a positive feeling for each other within the nursing faculty and as a strength when challenging times require a strong foundation of caring and respect.

Summary

The Caring Workshop provided space for the faculty to share their individual stories and to explore how their understanding of caring was connected to the understanding of others. Through this exploration of the individual and the collective perceptions of caring, shared themes emerged.

SHARED THEMES

As the Caring Workshop themes were constructed, it became apparent that they were related to the individual themes and in fact shared themes were emerging. As the individual and workshop themes were compared with each other, shared understandings of caring were discovered along with an increased awareness of the faculty's commitment to caring for each other and for students (Lincoln and Guba, 1985).

The themes shared by the faculty are grouped under three main headings including: the nature of caring, the teaching and learning of caring, and challenges to caring. Again, the themes are numbered not to indicate a difference in level of importance but for ease of reference. The shared themes are as follows:

Nature of caring:

1. Caring for others is facilitated when nurses care for themselves.
2. Occasions are perceived as caring when the cared for determines the course of the interaction

The Teaching and Learning of Caring

3. The faculty perceived that caring was not "taught" in their nursing programs.
4. Caring is learned through experience and is an ongoing process
5. Uncaring experiences have a powerful impact on all faculty's personal perception of caring
6. Role models and mentors are important contributors to perceptions of caring

Challenges to Caring

7. Faculty perceive their personal responsibility to be caring as superseding the challenges to caring embedded in work life, gender and power issues.

Shared Theme 1: *Caring for others is facilitated when nurses care for themselves.*

Tina's words reflect what for the faculty is a foundational aspect of caring- caring for self. She states

> The difference in 'caring' and 'caring for' is you are truly caring because you are taking care of yourself. It isn't psychologically draining like it is the other way. You can let go. You can let other people make their choices and that to me is caring.

This was a theme found in all the transcripts and expressed at the caring workshop. Kim states "I think the most important thing in relation to caring ... is to identify how we are caring for ourselves as

individuals and then how we are caring as a group". Sharon feels the same way and provides concrete examples of caring for self when she says

> Unless you can take care of yourself and your own needs, unless you get a good night's sleep, unless you eat enough, if you are stressed out or have something, a crises happening in your life until you can deal with that then you can't really care. I really believe that.

Julie remembers caring for the emotional dimension of our lives when she states

> I am really concerned that we not only care for our students but how we care for our faculty and that for me is a really important point. This means not expecting ourselves to be perfect and letting ourselves make mistakes or acknowledging that we do make mistakes, and that is not the end of the world ... it doesn't mean you are a bad person or that you are an uncaring person.

This understanding of caring as caring for the self presents a dilemma and creates complexity for the faculty who have, by and large, been trained in a profession that separates service and self. (Benner and Wrubel, 1989; Attridge and Callahan, 1987). The self is often viewed as separate from and often in opposition to others thereby necessitating a way of being that pushes personal needs to the background if the needs of others are to be served. This is demonstrated by Tina's actions of going to work when she was unhealthy herself due to dealing with the death of her brother and a viral infection. These actions were characterized by others as "Oh what a good nurse. She is so dedicated and boy can she ever handle lots, you are so strong". Julie also found herself in a similar situation

when she was caring for a child who was very fussy because she was acutely ill with kidney disease. Julie talks about having to force herself to enter the room. She remembers thinking "Oh, I don't want to go in there again".

The tension created when nurses do care for themselves within a prevailing hegemony of selfless service is evident in the story of the nurse who was perceived as wanting her vacation regardless of the impact it had on other nurses with whom she worked. Kim also addressed this issue in the Caring Workshop by expressing her fear that her need to be with her young son and husband would be perceived by other faculty as being uncommitted to the curriculum.

This attempt to separate self and service is reflected in the working conditions nurses have traditionally been expected to work within and only recently begun to question. These conditions include: "the demands of working in complex organizations [where there is] chronic nursing shortages, ill-advised reductions in nursing staff.... and compressed salaries" (Benner and Wrubel, 1988). Nurses have, as a predominantly female profession, been subjected to low pay for performing highly specialized skills perfected after a minimum of two years of intense training, minimal input into the decision making structures that exist in health institutions, and the expectation that all the work will be done with minimal financial, human and physical resources (Bevis and Watson, 1989; Benner and Wrubel, 1989; Attridge and Callahan, 1987; Roberts, 1990). They have been expected to work under these conditions because a

commitment to caring for others has not been and often still is not perceived as compatible with caring for self.

The faculty perceive that trying to separate service and self promotes uncaring interactions. Until Tina recognized the toll this way of being was having on her life, she sees herself as caring for not truly being in a caring relationship with people. Kim recognizes that in her first year of teaching she "did not bring a lot of caring into [the] classroom". She goes on to say

> I couldn't care because there were too many other demands being placed on me and maybe those were perceived demands and not real demands. I had a curriculum to cover, that was a real demand. I had a certain amount of time to cover it in, that was a real demand. I had a new town to get adjusted to and a new place that I was living in.... Those were real demands".

Marnie experienced this same feeling in her first year teaching when she remembers not caring for herself and how this affected her caring for students. She describes herself as being very stressed, staying up late preparing for class, and being "quite sick that year".

The faculty recognize individually and together that as Benner and Wrubel (1989) state "in a phenomenological view of the person, in which the person is viewed as related to others and defined by those relationships, concern for others is not necessarily oppositional to or competitive with self-interest" (p. 367). Although the faculty are committed to caring for self, their stories also reveal that attempts to do so often create complexity in their work as caring professionals.

Shared Theme 2: *Occasions are perceived by the faculty as caring when the cared for determines the course of the interaction.*

> Allowing people to make choices is important.... This kind of caring is important because it respects people. It puts health care back to them and we are the facilitators of that. This is the only way we will really promote health (Participant quote, 1993).

The wording of this theme has been a difficult task because it is an attempt to describe something that is felt by each of the faculty and informs their way of being as caring people but is talked about in different ways. Marnie talks about paying attention to people and by paying attention she becomes aware of the other and this awareness directs how she will meet the other. Julie describes "valuing people" and through the valuing, she becomes aware of the needs of the other and this provides direction for her caring interactions with them. Pat is motivated to meet the other in a caring space which is determined by the other. Tina feels that by respecting herself and her choices, she can accept the choices of others and care for them where they are not where she thinks they should be. Sharon describes her actions as caring when she is available for others. Kim feels caring when the needs of the other are the determining factor in the decision making process. I describe myself as being caring in a relationship when I leave control with the other where it belongs. The faculty together in the workshop described this as valuing others and being committed to recognizing the influence of culture on caring.

All of these ways of caring are reflective of acting "with special regard for the particular person in a concrete situation". (Noddings, 1984, p. 24). The stories related by faculty reflect a shared perception of caring as occurring in interactions with others when the cared for retains control of life choices and determines what occurs in the interaction. Although this is often difficult because the physical or mental condition of the cared for may mitigate against the ability to be in control and make choices, faculty are committed to facilitating this process in their caring relations with others. The stories also reveal that faculty feel cared for when they determine their own life choices and when they are involved in decisions that affect their lives.

As nurses, the faculty easily categorize as uncaring, situations in which people's needs or ability for self-determination are ignored. Sharon labels as uncaring the tendency of the nurses in intensive care to stress the need for paper work to be completed over teaching patients about their heart conditions when they have indicated their readiness to do so. Kim labels as uncaring the head nurse who ignored the abilities of her staff to determine how they would do their work because she needed to "have her finger in everything [and]we didn't feel that she was trusting us to do our jobs".

Because they perceive as uncaring situations where the needs, abilities and self-determination of the cared for are ignored, the

faculty strive to counteract this in their own practice. Even though she dislikes the nurse who insisted on having her vacation regardless of the context of the situation around her, Marnie tries to "help her become aware of when she was uncaring". She also perceived herself as assisting the nurse in a way that didn't "threaten her self esteem...[that] paid attention to her and what her needs were". In her description of working with a young man who had a broken neck, Julie states "As nurses the most important things we did were not responding with anger when he got angry and understanding where he came from. He was so angry.... [We] didn't treat him like he was of no value". My feeling of needing to let Bill be in control of his life by listening to and following his directions about how his dressing was changed and wound irrigated, also reflects a recognition of caring as ensuring people have choices and determine the course of my interaction with them.

The faculty's perception of caring as ensuring that people determine their own choices is also evident in the way they describe their work as nursing instructors. Kim talks about providing an environment in which the students can "come out being whatever kind of nurse they feel like they need to be". She does this by

> helping them to move through the process rather then telling them how to go through it ...I [allow] them to be more themselves and bring their own experiences to the classes rather then setting some kind of goal and expecting them to attain it a certain way.

Julie describes dealing with a student who was having difficulty. She states: "I really looked at it from her perspective too. I was

encouraging rather then discouraging, available, listened and tried to set up appointments that weren't at a rushed time". She was aware of the student's need to discuss the issues and make choices about her work. Tina also recognizes the caring in ensuring students have control. She does not "give them the answers". She says

> I don't give them all the answers. I let them see what the implications are and I think that they learn more that way. To me it is the whole fact of respect and that hopefully they can find things in their caring that aren't quite right. I give them the opportunity to look for those kind of things. ... I just try to guide them and hopefully they learn more that way.

Shared Theme 3: *The faculty perceived that caring was not "taught" in their nursing programs.*

The impression that caring was not a part of the formal curricula through which the faculty received their nursing education, was a pervasive one. None of the faculty remember it as being addressed in their classroom experiences although several reported individual instructors talking informally about caring usually in relation to clinical post conferences. Sharon could not remember any caring talk in the classroom but thinks they "may have talked about caring [in post conference] a bit, about sort of how patients were feeling, what was happening with them, but I don't think we actually brought up 'How did you feel caring for this patient?'"

When asked specifically about caring in the curriculum, faculty responses included such remarks as:

> "I do not remember caring being taught in the curriculum at nursing school.... I don't remember talking about caring, or it ever being discussed in a post conference or anything like that".

and

> "When I went to nursing school, I don't remember particularly addressing the issue of caring"

The setting or length of time of the basic nursing training does not appear to be a factor in this perception. One of the faculty received her basic diploma in a three year hospital program, another attended a four year generic baccalaureate program, and five attended college programs all of which were approximately two years in length.

This perception is interesting from another point as well in that it is shared by people who graduated from their basic nursing education programs covering a span of years from 1962 to 1980. In fact Pat, who graduated in 1962, states:

> Caring was not addressed in our curriculum. We didn't even have anything on communication skills or interpersonal communication.

While Marnie, who graduated in 1980 states:

> I can't recall caring ever being mentioned in nursing school. I'm sure it wasn't, because I do remember that time fairly well. It was never discussed in class. There was no content on caring ever. I'm quite positive about that".

The literature reveals that although caring was not, and in many cases still is not, part of the explicit nursing curriculum in nursing schools, it was certainly beginning to be included as part of

behaviorist curricula by the late 1970's, early 1980's (Bevis, 1982; Bevis and Watson, 1989). This leads one to wonder if indeed it was not included or included in such a way as to be marginal to the student experience. It is also possible that caring was an important part of the formal curricula but student's learning priorities were concentrated elsewhere. Another possibility lies in the notion that caring may have been part of the "illegitimate " (Bevis and Watson, 1989) or "implicit " curriculum (Eisner, 1984). This is the curriculum that

> Values and teaches, among many other things, caring... This is the curriculum that, because of the constraints of the behavioral-objective driven curriculum prevalent in nursing , cannot be graded or officially acknowledged or sanctioned because it does not lend itself to descriptors that are behavioral." (Bevis and Watson, 1989, p. 75)

Sharon states "Caring was not part of my nursing curriculum that I can remember. I think we definitely learned about caring but we didn't learn it in a structured way." Although Pat does not remember caring being in the curriculum, she does remember "a couple of instructors who will always stand out in my mind as being incredibly caring people who were kind, who talked to you". Julie recalls very vividly an instructor who did talk about caring a lot.

> She really made you feel what it was to be with people and to relate to people and how people impacted on our lives and how we could impact on theirs.

Although faculty do not remember caring being a formal part of their curricula, their stories do reveal opportunities to observe and be part of caring interactions and learn from them. The memories of

caring instructors and how they were as people suggest that nursing teachers perceived caring as worthwhile to the profession and chose to actively teach it through example and discussion (Bevis and Watson, 1989).

Shared Theme 4: *Caring is learned through experience and is an ongoing process.*

Without exception, the faculty perceived that they learned caring. They do not perceive it as a way of being with which they were innately endowed. They also perceive that they are continuing to grow as caring professionals and in fact are very committed to doing so.

All faculty describe childhood experiences with caring that informed their being as caring individuals. Marnie provides evidence of this when she describes how her mother knew that she had sore ankles despite the doctor's opinion that it was not so because he had no medical evidence to support it. Her mother paid attention to Marnie and cared for her in this way. Sharon describes how she felt cared for in her family because her parents "did things for me, they bought me ice cream. They played with me, they took us out, they spent time with us". Kim states "My mother taught me about caring just in the way she treated us. She listened to us a lot". Julie also felt cared for in her family. She says "My parents were older when they had us and they were very caring people. They really put our needs first. We were a focus for them. So I think I

grew up in an atmosphere where I felt valued". I also perceive myself as being part of a caring family and learning from that. My mom's honesty with me and my dad's spending time with me felt caring. Sharon's interactions with the elderly man and woman whose relationship demonstrated the power of caring , Julie's appreciation of the nurse caring for her dying parent by hugging him, Tina's feeling of being cared for by the nurse who recognized her pain in dealing with an ectopic pregnancy, and my experience of watching the growth of baby Gail's family, all contributed to our continually developing sense of caring as an important part of who we were and how we wanted to be.

This understanding of caring as being learned through experience is actually stated by faculty not only in the individual interviews but also in the Caring Workshop. Kim says "Although caring wasn't in the curriculum, I learned about it just through personal experience". Sharon puts it this way "I think experience with nursing and growing up....I think that makes a big difference" while Tina says "Allowing people to make choices is important. That is how I learned a lot of my own lessons". All of Pat's stories confirm that she perceives she learned to be caring through experience. She says things such as: "a couple of incidents really stand out for me as the way I learned about caring".

The individual and shared understanding that caring is learned through experience is perceived by faculty as most important

revelation. This is so because the development of learning activities can be structured to take this into account.

Shared Theme 5: *Uncaring experiences have a powerful impact on all faculty's personal perception of caring*

The faculty perceive that through seeing, experiencing or being part of uncaring experiences, they have learned about caring. In fact uncaring occasions have a very powerful impact on their commitment to and recognition of caring. This understanding of the impact of uncaring occasions is seen in the individual themes as well as directly stated by Julie in the workshop when she said "Both Marnie and I recognized the impact of ...uncaring experiences at a very early age".

The faculty stories reveal that the faculty perceive a complex range of behaviors and attitudes as uncaring. This is evident in their labeling as uncaring such disparate incidents as feeling badly if a medication was delivered twenty minutes late to feeling uncaring if they find it difficult to accept client behaviors such as urinating on the nurse or physician behaviors which ignore patient safety.

As in other themes, faculty talked about uncaring in their early lives and how it impacted on them as persons. Sharon and Julie both experienced the uncaring in the fact that classmates were denied permission to go to the washroom and as a result were incontinent in front of their classmates. As a candy striper, Sharon recognized the uncaring of the "big fat nurses" who remained at the desk and did

not answer the patients' call bells. She determines that she will not act like this when she is a nurse. Marnie and Julie both recognized the uncaring that can occur because of differences in culture or race. A concern they discussed in the workshop as well.

All of the faculty have witnessed or experienced uncaring in their work as nurses in practice or as nursing instructors. Julie recalls feeling uncared for when the woman reported her to the doctor as leaving her bedside unit untidy. Kim felt uncared for at her employment interview for North Island College when the Assistant Center Director was "cold and insensitive" to her as a prospective employee. Sharon felt very uncared for and abandoned as a student.

Although the litany of uncaring stories is long, the faculty hang on to remembering the experiences as they understand who they are now because of them. Kim says

> I learned about [caring] just through personal experience and experiencing what uncaring was and knowing that being able to identify in people or see situations when I know how I would have felt in that situation and not wanting to put anybody else in that position.

Tina, returning to her theme of choices, also learned about caring from being uncaring for herself. She states "From those choices, even destructive choices, it taught me a lot about allowing other people to make choices that may cause them pain but pain isn't always bad. You can really learn from it." Pat also learned from uncaring experiences and she expresses it this way "There are... uncaring situations that happened that I think helped me to focus on

the fact that I wanted more from my nursing and knew that I could bring more to it".

Shared Theme 6: *Role models are important contributors to perceptions of caring.*

All faculty describe the importance of role models in their development as caring professionals. They perceive that seeing caring being practiced and the experience of being the cared for by expert caring practitioners as instrumental to their own perceptions of caring. They also perceive caring as something that we, as a faculty, must model in order to be effective in assisting students to grow as caring professionals. In Tina's words "we can't just talk the talk, we have to walk the walk". Together in the workshop, the faculty expressed this by stressing the importance of being treated with sensitivity by others. They perceived this as providing them with a model of a way of caring to which they aspired.

Although the faculty do not remember caring as being part of the formal curriculum in their basic nursing programs, they all remember particular instructors as being important to their understanding and learning of caring. Kim remembers an instructor who was very competent and who felt very comfortable stepping in to patient situations and helping patients in a caring way. I remember a pediatrics instructor in much the same way. She lived caring in her interactions with students as well as patients and gave me a beginning understanding of what nursing was all about. Julie

talks about students becoming aware very early of instructors who were "more concerned with their physical appearance then what was happening with the students, who would yell at students in front of patients, who put students down". She contrasts this with an instructor who "did talk about caring a lot....She really made you feel what it was to be with people and to relate to people and how people impacted on our lives and how we could impact on theirs. She was a really neat lady....She probably impacted more then I realize when I start thinking about it". Pat learned a lot from the instructor who made sure the unconscious teen age girl's life was recreated in her hospital room. This was powerfully important to Pat's perception of caring because when the girl regained consciousness she remembered everyone's name. Marnie remembers the instructors who anticipated her needs, bent the rules for her, took everything into account, and discussed things with her. This helped Marnie feel "unique and an individual".

The faculty have translated these positive experiences with instructors into ways of being with students themselves. Julie values students, spends time with them individually and concentrates on the positive. Tina doesn't want to know student's previous histories. She wants to

> Find the positive in that person and build on that. So even though if I may see something that really needs, in my view, to be worked on, I don't look at that. I find it's better if I find the positive and say what contribution they are going to make to nursing and in doing that it puts the negative down.

Sharon consciously remembers her own experience with instructors to inform how she is with students. She states

> I guess [it] stems back to being a student and wanting, feeling that an instructor should be approachable and thinking well if I'm not patient with them, if they are uncomfortable with my reaction, they are not telling me something then they are not going to tell me anymore. They are going to go to someone else to find things out ...I certainly don't want be to be perceived as an unapproachable bitch".

Pat talks about wanting "to create a relationship with students where people felt they could talk to me, that I would make time. I shared some of my life with them, like who I was so they would feel comfortable sharing with me and really not having that barrier".

The faculty's perceptions of being available for students, modeling caring and sharing of themselves as being effective ways to assist students in learning caring, reflect research done by Beck (1991). She found that students' perceptions of caring faculty were expressed in terms of an attentive presence, sharing of selves and feeling respected and valued as an individual (Beck, 1991, p. 21). It is interesting that the faculty have come to understand a way of being with students similar to the way students in the study wish to be cared for.

Shared Theme 7: *Faculty perceive their personal responsibility to be caring as superseding the challenges to caring embedded in work life, gender and power issues.*

This theme grew out of an attempt to identify challenges to caring. From reading the literature on caring, I expected faculty to specifically identify work life, power and gender issues as important factors affecting their ability to care. The faculty had access to the interview guide before the interview. The guide did not address these issues specifically but did ask for their thoughts on what factors were challenges to their being caring. I did not structure the interview to specifically ask what it meant to be a woman in nursing and what effect administrative or work life structures had on their caring abilities. The few times I tried to introduce these topics I felt the faculty were not prepared to address them or were not perceiving how they related to caring. For me this is a theme in that it fits Merriam's (1988) description as one that "stands out because of [its] uniqueness and should be retained" (p. 135).

Tina identified several challenges to caring which included: lack of time although she also saw this as a cop out; stress in one's personal life; and family history. Sharon identifies a challenge to her ability to care as "old school" meaning "skills are more important, physical needs are more important than psychological [needs]". She also believes that "being under a lot of pressure affects people's ability to care". Marnie and Kim both feel uncared for when they are not included in decisions that affect their ability to care but they

do not attribute this to gender issues or specifically to an issue of work life or power. They also describe being unable to care for students in their first year of teaching because they were stressed out and very busy learning the curriculum. Pat sees people's ability to care as challenged by inexperience.

All of these challenges can be discussed in terms of gender and power and in the context of nursing being a female profession. In fact many of the faculty's stories have these issues embedded in them. Kim's story of the head nurse who had to have her fingers into everything, Marnie's story of the nurse demanding her vacation, and Sharon's story of ensuring the family talked with the patient who had the aneurysm, are examples of this The faculty did not choose to see these issues from these perspectives. I have thought of several reasons why this may be so.

In all their stories and in their relations with one another, the faculty demonstrate an overriding need to be caring. This need to be related to the other in caring (Benner and Wrubel, 1989; Gilligan, 1982; Bevis and Watson, 1989; Noddings. 1984) may contribute to the faculty's perceptions that if nurses fail to care it is a result of their own inability not a result of the circumstances in which they find themselves. Sharon's description of the distress of her colleagues in the Intensive Care Unit when she delays attending to processing the doctors orders to take advantage of a teachable moment for patients, is not perceived by her as a work load issue. She perceives their distress as a judgment of her misplacing her

priorities or as their failure to recognize the importance of patient teaching She does not discuss what happens to the work when it gets busy and there is not enough staff. She does not relate their distress to a task oriented perception of nursing nurtured by the medical profession and hierarchical structures (Bevis and Watson, 1989; Benner and Wrubel, 1988; Growe, 1991). When Kim and Marnie feel stressed out during their first year of teaching, they do express anger at not having their work recognized, but they also feel personal responsibility for not being cognizant of the fact that they needed to relax. They do not talk about the necessity for an appropriate amount of time to be administratively allocated for their orientation to a new situation. They do not discuss the challenges of a system in which they were alone and often felt unsupported. When Tina describes using time as an excuse to "cop out" of caring, she is seeing this as a personal failing of nurses. She does not describe the effects of patient load, lack of staff and the pressure of increasingly complex technology on nurses. (Bevis and Watson, 1989; Benner and Wrubel, 1989).

The fact that the faculty received their nursing education at a time when schools of nursing had curricula based on behaviorist objectives using the medical model of cure as opposed to care, and in which they were expected to receive knowledge not construct it (Friere, 1972; Bevis and Watson, 1989), may also contribute to their understanding of uncaring as resulting from personal rather then

cultural challenges. The faculty have grown up and practiced nursing within a prevailing hegemony of medical science

> Wherein what it means to be a physician and what it means to be a nurse is based on a system of control, manipulation and domination of one over the other; a system wherein disease is separate from health and something to be controlled, something disconnected from the person and separate from nature....Nursing, of course, as a subset of medicine , is to be similarly directed, dominated and controlled (Bevis and Watson, 1989, p. 46).

Another possibility which may explain the faculty's perception of personal responsibilty for caring may arise from the fact that the focus of the research was caring. The faculty were exploring their growth as caring professionals and were not specifically asked to comment on other issues. Perhaps if issues of power, gender and worklife were addressed directly, they would interpret thei stories in a different way.

Summary

This discussion of the faculty's individual and collective perceptions of caring has revealed a commitment to caring as the focus of their nursing practice. This commitment is reflected in the individual, workshop and shared theme constructions.

In an effort to provide an overview of the relation of the themes, Table 2 Appendix D, was developed. I struggled with the appropriateness of presenting the constructions in what seemed a "positivistic" format. The table is included because it is a visual

display of the theme constructions that "snaps...significant relationships into sharp focus for the reader" (Van Dalen, 1966, p. 431).

The construction of the themes has also revealed that the faculty share many perceptions of caring but also understand it within their own context and experiences. They have arrived at these understandings through experiencing caring and uncaring occasions, through seeing caring as lived by others, and through sharing their experiences with one another.

CHAPTER 5

Promoting Growth as Caring Professionals

The nursing faculty at North Island College are committed to assisting students in their growth as caring professionals and assisting faculty to continue to grow as caring professionals. Through the process of exploring caring individually they became aware of how their own perceptions of caring were constructed. They also became aware of how their perception of caring had changed and was changing. Faculty also confirmed the ontological authenticity of the research by recognizing that their understanding of caring had been expanded and elaborated by having to think and talk about it (Guba and Lincoln, 1989). Julie stated "Can anybody be taught to be caring? [This]has made me really step back and think about it". Pat also expressed this by stating "I have never explored my growth as a caring person before this and I probably wouldn't have called it caring". The catalytic authenticity of the research was confirmed by the faculty's demonstrated commitment at the Caring Workshop to promote caring in the NIC Nursing Program as a core value of nursing and a way of being with others which promotes health and healthy choices (Workshop notes, 1993; Guba and Lincoln, 1989; Lather, 1991).

The faculty want caring to be explicit in the curriculum rather then part of the illegitimate or hidden curriculum as in the past. For the faculty caring involves valuing of self and others, caring for self,

respecting differences and promoting personal control over life choices. Caring is learned, reinforced and affirmed by opportunities to share experiences with others and come to an understanding of their impact on the caring self.

As they explored their caring journeys individually and together, the faculty also became aware of the complexities of assisting students to become caring professionals. The tensions created in caring for self, the need to ensure that the curriculum reflects a commitment to continually questioning and changing the prevailing hegemony, and the understanding that the curriculum must remain open to ways of knowing caring that the faculty has never considered, are challenges which must be addressed in incorporating caring into the curriculum.

The faculty's individual experiences with caring and our collaborative discussion of these experiences provide direction for and commitment to the development of strategies that may assist students in their growth as caring professionals. The faculty also want to promote this caring among themselves and in the college as a whole. This chapter discusses these strategies organized around several of the shared themes constructed from the individual interview transcripts and from the workshop discussions. The themes around which the strategies are developed were those identified by the faculty in their interviews and in the workshop, as important to address as they begin working with the new curriculum. In this discussion the theme that identified the faculty's

perception that their personal responsibility to be caring superseded the challenges to caring of work life, gender and power issues is not addressed specifically because the strategies which address the other themes will promote the students' and faculty's exploration of these issues as they affect their ability to care.

Theme 1: ***Caring for others is facilitated when nurses care for themselves.***

The importance of caring for and knowing self was recognized by all of the faculty as being important in caring for others. Caring for self is not only important for faculty in assisting students but also for students to learn as they progress through their education as nurses. For the faculty, knowing self is also caring for self. Knowledge of self is caring in that it enables the recognition of strengths and limitations.

Faculty and Caring for Self

In their efforts to be caring with students and others, faculty recognize the need to ensure that we care for ourselves as individuals and care for the faculty as a group. Some strategies for endeavoring to ensure this include budgeting individual and group "reflection" time, committing to collaborative decision making and providing professional development opportunities which enhance and broaden our understanding of caring.

Individual and Group Reflection Time:

In their discussion of where we have been as a faculty in relation to caring, the participants in the research recognized that prior to this past academic year, our opportunities for sharing with each other were restricted to two to three articulation meetings per year and to numerous telephone conversations. Within the past year, however, the impending implementation of the Caring Curriculum has necessitated frequent meetings. The continuation of frequent, sharing time is perceived as essential to our growth as caring teachers. The faculty also expressed a need to have personal time for reading and reflection built into our working schedule.

In this time of budgetary restraints, it is recognized that the need for individual and group time must be met within the existing hours allocated to the nursing faculty. Ideas for accomplishing this include: flexibility in teaching roles and scheduling of a time to reflect and learn together each week.

Flexibility in teaching roles will require consultation among faculty. Recognizing the educational advantages of continuity in teacher/student interactions (Bevis and Watson, 1989; Noddings. 1984), faculty may negotiate hours not scheduled for actual teaching but scheduled for support work such as course preparation, student admissions, curriculum co-ordination and community liaison hours. The negotiation of individual time will require advance planning which may be accomplished by scheduling a planning meeting on a

regular basis. Faculty may also choose to negotiate time with each other for personal development.

Scheduled weekly individual and group sharing and reflection time are seen as essential by the faculty. It is a time for the teachers to attend to the "primary duty to develop the self" (Bevis and Watson , 1989, p. 164). "Faculty development [together] must occupy a dominant place in faculty life and must itself be a mode of active learning" (Bevis and Watson, 1989, p. 175).

Collaborative Decision Making

The caring process is perceived as dynamic and changing reflecting our growth together as people committed to caring for self and each other. We want to accept differences, become comfortable sharing and taking risks in our relationships, be honest in sharing feelings, and to resolve issues associated with intense personal meaning. The faculty's commitment to living the caring of the curriculum, reflects their perception, as discussed by Tanner (1991) that "caring is learned by experiencing caring practices between faculty and students , and that is only possible when the culture of the school supports enactment of caring practices among faculty" (p. 71).

This culture can be nurtured through a process of collaborative decision making within the faculty and in the college as a whole. The collaboration envisioned here is similar to that defined by Pike, McHugh, Canney, Miller, Reiley, and Seibert (1993):

> Refers to a process of working one with another. It is not synonymous with cooperation, communication or compromise. These words do not connote the richness embodied in a collaborative relationship. Collaboration involves trust and respect not only of one another but also of the work and perspectives each contributes. The concept suggests a bond, a union, a depth of caring about each other and the relationship. It incorporates notions of a synergistic alliance that maximizes the contributions of each participant (Pike, McHugh, Canney, Miller, Reiley, and Seibert, 1993).

This collaboration may be fostered within the faculty by using a feminist process of group work as described in Wheeler and Chin (1991). Through establishing "Principles of Unity" for our group work and through a recognition of our power together (Kreisberg, 1992; Wheeler and Chin, 1991), caring decision making may be lived and modeled for others.

This commitment to sharing decisions is also a commitment to caring. The faculty want to promote such a commitment throughout the college by promoting shared governance as the college decision making process (Musante, Coleman and Kneeland, 1992). The Campbell River and District General Hospital has a shared governance organizational structure and several of the nursing staff from that institution volunteered to talk to agencies interested in such a process. As a first step in promoting the implementation of shared decision making, one of these volunteers could be invited to talk about the experience of shared governance with the nursing faculty. The faculty could then examine their own decision making process to determine the fit with the work as a group. If the fit is deemed to

promote caring, the implementation of shared governance within the college could be promoted by initiating a beginning awareness of the process through liaison with management and the faculty association. In this way a beginning awareness of shared decision making could be engendered throughout the college. Further plans for implementation would proceed as indicated by reactions to the nursing faculty's initiatives.

Professional Development Opportunities

The Collaborative Curriculum has developed not only through a process of collaboration by the collaborative partners but also through a process of professional development. The North Island College Nursing Faculty joined this collaborative effort three years after it began. The faculty, therefore, need to become familiar with the history, philosophy and concepts of the curriculum as a shared resource. This will be facilitated not only by individual and group reflection time but also by formal professional development activities (Bevis and Watson, 1989; Benner and Wrubel, 1989). These activities could include continued attendance at and membership in all Collaborative Curriculum committees and college sponsored attendance at conferences and workshops on caring and other curriculum concepts. The faculty could also share the materials constructed in this research with the collaborative

partners. This would promote our sense of contributing to the collaboration and also facilitate feedback for our further development as a caring faculty.

Students and Caring for Self

Just as the faculty have learned that caring for self is essential if caring for others is to be achieved, opportunities for students to learn this must be provided as well. Activities that could provide such opportunities include: ensuring that students make an informed decision about nursing as a career, and ensuring that students are aware of "tools" to assist them in dealing with stress in their lives as students.

Caring and Informed Decisions

By ensuring that nursing is where they want to be, students are caring for themselves . Faculty can facilitate this decision by providing pre-admission opportunities for students to become aware of nursing as a profession (Ruehlen, 1992). This can be achieved in part by organizing a compulsory information session for students prior to their entering the nursing program. This session could include a panel discussion of nursing. Panel members could include a nursing student, a faculty member, and a nurse from a hospital. Panel members would be asked to describe their views of nursing and what they wished they had known about nursing before making the decision to enter nursing school.

By providing a picture of what nursing is like in the real world, it is hoped that students will care for themselves by ensuring this is the profession for them. In this way caring for others may also be enhanced in that people who truly want to be nurses are entering the profession.

Caring and Tools to Assist with Stress

Several of the faculty perceived that their caring was compromised when they were under stress and unable to care for themselves appropriately in stressful situations. Students in a nursing program will experience stress and opportunities to learn ways of dealing with this may reduce the effects of the stress, thus enhancing care for self and others.

As students, the faculty remembered several things that caused stress for them. These included lack of time, too much to do, personal and family issues, poor diet, lack of sleep and disorganization. By providing information to students about resources for dealing with these issues, the students may take action to reduce their stress and thereby be available to care for others.

The students could be provided with opportunities to meet the college financial advisor and the college counselor. Information about the services they provide, their schedules and how they can be accessed may be useful to students dealing with issues related to finances, student and family life (Ruehlen, 1992).

The students should also have access to a course in studying effectively. North Island College (NIC, 1993-1994, p. 110) has such a course and the nursing faculty is planning to encourage students to enroll in it as part of their nursing program.

In becoming aware of issues about their own mental, physical and emotional health, students are then able to choose to take control of their own health and care for themselves in this manner. In the Collaborative Curriculum, several courses are designed to facilitate student awareness of these aspects of their person. The nursing course Self and Others I is designed to provide students with opportunities to explore their own personal meaning, values, beliefs and perceptions and recognize how they affect their interpersonal relationships. Another nursing course, Health I, is designed to provide students opportunities to explore

> Conceptual frameworks of health in relation to self. By reflecting on personal experiences, participants will have an opportunity to identify personal resources, challenges that impact health and to recognize the complexity of the change process as related to health promoting behavior (Collaborative Curriculum, 1992a, p. 1).

Through these studies students have information with which to make caring choices for themselves.

Theme 2: *Occasions are perceived as caring when the cared for determines the course of the interaction.*

Ensuring that the cared for determines the course of the interaction, is a factor in the way faculty determine the care in caring occasions. This is important for them in feeling cared for and in caring for others. It is also an important foundational construct of the Collaborative Curriculum in that health promotion is seen as ensuring that people have choices and are given information they need to make choices and determine the course of their own lives (Bevis and Watson, 1989; Collaborative Curriculum, 1992b). Strategies to assist students in understanding this perception will be those aimed at ensuring students have choices in their nursing education. Strategies will also be concerned with ensuring that students come to understand their profession from a health promotion perspective, defined as a "process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health" (Epp, 1986, H 39 102/1986 F)

Caring And Student Choice

Within the new curriculum, the commitment to ensuring people have control of their lives is paramount. The faculty have determined that this is not only a way of promoting health and healthy choices but it is also a way of caring. By ensuring that

students and faculty have choices together in learning activities, clinical praxis placements, and in group process, they are ensuring that caring occurs and is practiced .

An example of how choice can be incorporated in this way, will be discussed using the nursing course "Self and Others I" as a guide. This course is designed to

> Focus on the process of understanding one's intrapersonal and interpersonal experiences. Through interaction and reflection, emphasis will be placed on understanding how personal beliefs, values, experiences and perceptions relate to and impact on our experiences with self and others. (Collaborative Curriculum, 1992a, p. 5).

The course content is to be organized around concepts such as beliefs and values, caring, self-esteem, self-concept, gender, hegemony, culture, feelings, perception and personhood (Collaborative Curriculum, 1992a, p. 5-6). Keeping these concepts in mind, two of the faculty at North island College developed details for the course providing choice in several ways.

The students will be able to choose one or more of three learning activities covering each of the required concepts. The students will determine the order in which the concepts are explored. The learning activities developed by the faculty and the Collaborative partners, will be evaluated by the students, faculty and the Collaborative partners on a regular basis.

Small group work will be used extensively in this course. Students and faculty together will decide on the group structure and organizational principles.

The students will also have opportunity for choice in the evaluation of their progress in the course. Through choice in evaluation activities, and through a system of contracting a grade, the students will be responsible, in large part, for evaluation of their own work.

The textbooks for the course have been chosen by the faculty through a process of consultation with each other. Articles, books and other materials important to students and faculty may be introduced for use in the course at any time.

This overview of providing choice in learning, is only a small part of a very big concept. Students and faculty together can also be encouraged to develop nursing program policies such as a policy concerning dress code for clinical placements, admissions and readmission policies, as well as policies for program and faculty evaluation. The process of choice must be respected and lived by the students and faculty if it is to be a living, caring part of our being (Musante, Coleman and Kneeland, 1992; Beck, 1991).

Caring and Ensuring Choice for the Cared For

In a profession fraught with many opportunities to "control" the lives of others, strategies designed to provide students with the opportunity to learn the importance of promoting healthy choices *in*

others instead of deciding healthy choices *for* others will be necessary if the student is to become a caring professional (Benner, 1984; Bevis and Watson, 1989; Benner and Wrubel, 1989; Tanner, 1991). In part this will be achieved by the strategies outlined above in which the student has been given choices and therefore been nurtured in a caring environment by the nursing faculty (Tanner, 1991). Other strategies will include studying nursing from a health promotion perspective rather then a cure perspective, and meeting clients in their environments as well as in institutions.

Caring and Health Promotion

As demonstrated by the story of baby Gail and her family, respect for the client's ability to determine life choices is caring and opportunities for students to learn this are important. Approaching nursing care from a health promotion perspective in which the client is seen as the determiner of life choices and the nurse is a resource for the client, is a way of ensuring control of health and healing experiences stays with the cared for. It is also a way of increasing student awareness that "health promotion is effective public participation based on the realization that health is determined by people's way of life and their interaction with the environment" (Stachtchenko, and Jenicek, 1990).

The Caring Curriculum's approach to nursing and to the client is from a Health Promotion perspective. All courses are based on this foundational construct and students will experience it personally in

the first semester when they complete a personal health profile looking at ways of promoting their own health.

Students will also be encouraged to explore how issues of culture, gender, hegemony and personal values and beliefs affect how they meet the cared for and promote or inhibit caring. Opportunities for this exploration will be provided by including these concepts in first semester courses through the use of small group, experiential and "living lab" activities. Such activities could include visits to refugee centers, visits from cultural groups particularly First Nations People as they are people with whom nurses come in contact often with limited understanding of their culture and health perspectives, and exploration of issues affecting women such as oppression and power (Friere, 1970; Bevis and Watson, 1989; Benner and Wrubel, 1989).

By being aware of the ways in which their experience affects how they meet others, students can then choose to be caring by ensuring the cared for is in control of their own life and of promoting their own health.

Caring and Meeting the Cared For at Home

The opportunity to control others is most likely to occur when the other is placed in a setting with which they are unfamiliar and often vulnerable as a result of illness such as in hospitals. Providing opportunities for student nurses to care for clients in their own settings provides opportunity for students to perceive the

importance of client control over health choices as they live in the world (RNABC, 1992a; The British Columbia Royal Commission on Health Care and Costs, 1991). This way of approaching nursing also cares for the student who is entering a profession that in British Columbia is currently being reformed to ensure that "medically necessary services [are] provided in, or as near to, the patient's place of residence as is consistent with quality and cost-effective health care" (The British Columbia Royal Commission on Health Care and Costs, 1991, p. A-6).

Strategies for ensuring that students meet the clients in *their* world are almost limitless. Students will be visiting a "resource'" family of their own choosing several times a semester over five semesters (Collaborative Curriculum, 1992b). This family will provide opportunity for students to see how a family experiences health, illness, and healing. The students will also explore with the family what resources they have, what resources they require and what resources are available as they develop personal health styles in their growth as a family.

Students will also visit families dealing with chronic and acute health challenges. The nursing students will observe how clients with a chronic health challenge such as diabetes or paralysis live with the challenge and make personal meaning of it. Students will also visit clients who are recuperating at home after having surgery in hospital. These learning activities provide opportunity for students to develop an understanding of different ways of knowing

and caring for the other in their world not one of the nurses choosing and the health system's construction.

Themes 3-6:

The faculty perceived that caring was not taught in their nursing programs.
Caring is learned through experience and is an ongoing process.
Uncaring experiences have a powerful impact on all faculty's perception of caring
Role models and mentors are important contributors to perceptions of caring.

Strategies for all of these themes will be discussed together as they are perceived as interrelated and overlapping. Strategies will include those aimed at making caring a living part of the curriculum and therefore recognized by the students as being in their education as nurses, those aimed at exploring caring and uncaring experiences and those aimed at enhancing faculty's role modeling of caring.

Although it is recognized that the faculty described a wide range of behaviors and attitudes as uncaring, the strategies do not specifically address the issues of why this is so. The opportunity to explore the significance of uncaring occasions may provide some insight into and encourage future research of the complexities of caring and uncaring situations.

Caring in the Curriculum

Faculty are committed to implementing strategies that ensure students are aware of caring as a living, driving force of the nursing program. Theses strategies include ensuring caring is included in program goals, including caring in all courses and making caring a visible experience in the classroom.

The goals of the North Island College Nursing Program are those of the Collaborative Curriculum. These goals reflect the attitude that caring is the driving force of the program. Goal number 1 states that the graduate of the program will "Practice nursing with a health promotion perspective and an ethic of caring within a variety of contexts and with a diverse client population" (Collaborative Curriculum, 1993, Part II, p.3). The students will receive copies of the program goals and will be addressing program philosophy and goals within the first few weeks of their nursing program studies.

Each nursing course will also include caring as an overriding concept which will be addressed within the second day of classes. All concepts in each course will be looked at with caring as guiding how they are studied. An example of this would be the study of personal meaning. Students will explore how they have constructed personal meaning of health and healing and how the perceptions of others reflect their own personal meaning of such experiences and must be a basis in caring for the other (Collaborative Curriculum, 1992b).

Making caring visible in the classroom can be accomplished in several ways. I will describe one here recognizing that as the students and faculty grow together caring will become more visible in their interactions with one another in ways they determine (Bevis and Watson, 1989; Noddings, 1984). They may also choose to physically indicate its presence in the classroom in a variety of ways of their own choosing.

The faculty determined that the development of a "Caring Book" would be a physical manifestation of lived caring experiences. The book will be written by students and faculty. The book will be available at all times for students and faculty to share their experiences by writing about them, inserting pictures or other items that reflect their caring selves, that have personal meaning. The inspiration to write a Caring Book was a collective one born in the Caring Workshop. The faculty recognized a need not only to talk about caring and meaningful caring stories, but also to document them for others to read, ponder and grow with. The Caring Book may include stories, pictures and other items that can fit into its pages such as pressed flowers, drawings, poems and locks of hair. It has also been suggested that a library of video tapes made by faculty and students which reflect things they wish to say about caring, may be part of the caring book idea. However the book develops it will be available to the nursing students and faculty at all times and will be kept in a place that is always accessible. The book will be a way of

sharing and learning about caring. It will also be a permanent record of our journeys together.

Ensuring caring is visible in the curriculum and recognized by students as such is seen as important by the faculty. The strategies mentioned above are a small part of the whole process of experiencing caring.

Caring and Uncaring Experiences

The strong perception by faculty that they learned caring through experiencing and observing caring and uncaring occasions, has prompted the development of strategies that address this. These strategies include:

- opportunity to explore personal experiences of caring and uncaring
- clinical placements for students in various agencies where caring and uncaring occasions may occur, be observed and/or experienced
- provision of reflection time wherein students and faculty may explore individually and together caring and uncaring occasions and make meaning of them in our growth as caring professionals.

Caring and Personal Experiences

Throughout the course of this research, the faculty discovered that they never really thought about caring nor did they discuss it in any detail with other nurses until requested to do so in their

interviews and in the workshop together. One of the faculty in her interview stated: "I have never explored my growth as a caring person before this". The faculty also perceived the exploration as beneficial in that they became aware of their own and other ways of knowing caring that could serve them well in interacting in a caring way with others. They expressed the idea that a similar process might prove important for students in assisting them to become aware of their own personal meaning of caring.

Becoming aware of who they are as caring professionals, can be explored by students when they are provided opportunity to take part in learning activities requiring them to think about caring and uncaring incidents that had an impact on their lives (Bevis and Watson, 1989; Benner, 1984; Benner, 1991). In small groups, students could discuss their varying and shared experiences of caring and uncaring. In this way they will have begun a process of self-awareness which can be reinforced by an expectation that ongoing exploration of caring issues is part of each nursing course and will be addressed whenever required.

Caring and Clinical Placements

The caring and uncaring occasions that were important for faculty as nursing students in understanding caring were most often associated with experiences in hospitals. The opportunities to perceive various ways of caring and knowing the world were bounded by the nursing school and hospital environments. Exposure

to various agencies will provide exposure to different ways of caring. The Caring Curriculum supports this concept and students, in consultation with health agencies, are encouraged to access varying experiences that will inform who the student become as nurses. The communities in the North Island College region have many agencies that students could access. These include child development centers, child and adult day care centers, non-governmental community agencies such as the Association for Community Living which supports mentally challenged individuals, Community Mental Health Centers, Homemaker Societies, Environmental groups, community action groups, volunteer agencies such as Hospice, correctional institutions, Family Planning Clinics and self-help groups to name a few. Each of these experiences will provide exposure to ways of caring and being that the student can choose to explore and incorporate into their caring relationships with others (Collaborative Curriculum, 1992b; The British Columbia Royal Commission on Health Care and Costs. 1991; RNABC, 1992a).

This idea of a clinical placement experience for students as being any place where they can practice nursing with an ethic of care and in a health promotion perspective is one which broadens the scope for experiencing caring. Each student will have a different experience and this will be shared with other students in reflection.

Caring and Reflection Time

As their growth as caring professionals begins and continues, students, as well as faculty, will require time to reflect upon their journeys individually and together. This can be accommodated by ensuring that seminar time devoted to discussion is part of the nursing program and considered an important part of the student's week (Collaborative Curriculum, 1993,); Bevis and Watson, 1992; Noddings, 1984). It can also be ensured by scheduling regular segments of each nursing course as individual time for reflection. Students will be encouraged to begin and maintain a journal to document their caring journeys. Journal summaries will be shared with faculty and fellow students so different patterns, and ways of knowing can be explored together (Cameron and Mitchell, 1993; Callister, 1993). Students will also be encouraged to make entries into the Caring Book and in that way contribute to their history as a class.

The commitment to reflecting orally and in writing, individually and together, on experiences which inform personal perceptions of caring, is also a commitment to evaluating together the students' and teachers' growth as caring professionals (Bevis and Watson, 1989; Noddings, 1984). Through the process of reflection the students and teachers may

> Catch a vision that although a student may not have memorized the desired answer an may not know the expected responses, perhaps the student has caught a glimpse of other equally valuable things an perhaps has developed insights and

> awarenesses that transport him or her beyond the answers into patterns and meanings. (Bevis and Watson, 1989, p. 301)

The faculty's perception that caring and uncaring experiences inform who nurses are as caring professionals, has contributed to the development of strategies that ensure student opportunities to experience many ways of caring. The importance of debriefing about the experiences has also been recognized and supported in the commitment to scheduled reflection time.

Caring and Role Modeling

In their remembrances of nursing instructors who were important to their perception of caring, the faculty described these instructors as "warm", "approachable', "fun", "able to share" and cognizant of the students' "abilities" as students. They also perceived instructors who "knew [their] business" or "tied it all together" as important to their success (Hughes, 1992; Beck, 1991). In considering strategies for assisting students to develop as caring professionals, the faculty determined that their modeling of caring was essential. Many of the strategies already discussed will contribute to faculty's ability to model caring. The faculty reflection and sharing time, professional development opportunities and shared decision making are seen as promoting their ability to be caring instructors.

The faculty also perceive that their caring has to be genuine, a true way of being because "students will be very quick to pick up that anyone can talk the talk but if you don't walk the walk, that

would blow the whole program". This genuineness comes from being committed to caring and "recognizing the value in everyone".

Mentoring is also an option being explored as a strategy for assisting student's caring development. This is also seen as an excellent opportunity to include nurses in clinical agencies in the student's education in a very real way. Nurses in practice will be asked to act as "preceptors" for students during portions of their clinical experience. The students and nurses will be encouraged to develop a mentoring relationship if it feels appropriate (Benner, 1984).

The faculty are also discussing the idea of mentoring students. This could be organized in that each of the instructors would mentor four students. Students would be encouraged to identify a mentor and meet with her on a regular basis or as required to discuss concerns regarding nursing and their growth as caring professionals (Bevis and Watson, 1989; Benner, 1984).

As stated by Bevis (Bevis and Watson, 1989)

> Only a mentor/ preceptor/teacher modeling a humanistic caring ethic and having dialogue with students that underscores constructed knowing and encourages them to be personally related to the ethical issues involved can facilitate and enhance students in their moral development for life and for nursing" (p. 184).

Conclusion

This exploration of strategies to assist students in their growth as caring professionals has addressed faculty growth as well. The

two are seen as elements of the same thing because caring for self is perceived as foundational to caring for others. The complexities of incorporating caring into a curriculum are many with the potential for creating the same tension in the nursing school evident in the profession of nursing itself poignantly described in the faculty's stories.

The strategies discussed owe much to the vision of the original Collaborative Curriculum partners. The philosophy, goals, course outlines, learning activity guidelines and the perception of clinical experience as occurring where people live, in and of themselves promote caring as evidenced by their fit with faculty themes. We are, as a faculty, aware of the resource this curriculum and those who developed it are to us and to students as we start on this new part of our caring journey together.

EPILOGUE

I could not leave this research without a final word about how I have changed because of being part of it. Some of the change is a result of the research process itself. Some of the change is a result of my discovery of, and surprise at, the different ways of viewing caring. Finally, some of the change is really not a change at all, but an affirmation of my feeling of the importance of caring in the real world.

Before I began this research, in fact before I began my studies at Simon Fraser University, my idea of research was that it involved a process of numbers, control groups and written documents that were only as valuable as they were incomprehensible. As I thought about caring and progressed in my courses, I was aware that my idea of research would not be useful for me and the way I thought about caring. Thus, my discovery of qualitative research was like my discovery of the Caring Curriculum - it fit who I was and what I wanted to study right away. As the process developed and the research progressed, it fit even more but was also very overwhelming and still is. The very large issues of power, gender and culture, embedded in the faculty's interviews, although not ignored, seem to require another thesis or two to do them justice. I feel I have only barely begun to understand all the things the faculty shared with me and have doubts about the justice I did with the stories they shared. I am , therefore, very pleased that the faculty

were a real part of the research as this relieves my anxiety somewhat. Their input throughout reassured me that I was saying what they were expressing through their stories and not merely putting my ideas on their words. Their comments about the transcripts and the theme constructions confirmed this for me as well. Kim commented that she was "Amazed at how I made sense of all that stuff I said". Pat, who had recently completed a personality inventory, and reluctantly accepted the results, commented "You really captured what I said. I didn't believe that I was that personality profile but when I read my themes I saw it right there". Julie, who expressed some fear in the interview that I would impose my understanding of caring on the stories, commented "It really captures what I think. I was surprised though at the cultural thing but it is certainly there". These comments were very important to hear because I was committed to ensuring the voices of the faculty spoke in the research. I hesitate to say it, but it felt like a very caring way to do research. So my ideas about, and understanding of, research are poles away from where I started - a change indeed.

In the stories, and in the constructing of the themes from the stories, I learned about caring in ways that never occurred to me. There were surprises. It was surprising to learn that, for two of the faculty, competence to practice nursing made them feel more competent to care. I had assumed that the caring came first and everything else followed. For them it was not quite so clear and I

think now it may be a combination of both. Maybe we care for others by caring for ourselves when learning new things. By turning inward and concentrating on mastering something new, we are ensuring competence and caring practice. There may be other explanations which future research could explore. Another surprise, which suggests a very important area for further inquiry, was the recognition that the faculty, myself included, describe as uncaring a whole range of behaviors and attitudes that would seem to require very differing responses and consideration.

I was surprised to think about caring being a choice. I knew I often failed in my attempts to care in a way that was for the other but I never thought of it as a choice. Now I know caring is a choice and I look at the stories in my journey and see that "choice" is also a theme for me.

Kim's statement that "If I know how to be uncaring, it's like a weapon almost that I could use against somebody" was a big surprise to me but now makes sense. As I think about a nurse with whom I worked and how she was inflexible with visiting hours in all situations to the point of being uncaring, I see her using those regulations as a weapon of power. This is a scary idea that fits in with the larger issue of oppression requiring more study and awareness on my part.

My increased knowledge of the faculty's perception of, and commitment to, caring for themselves, each other and students, has changed my attitude to caring in that I now see it as even more

necessary then I did before. Through their willingness to take such an active part in the research, the faculty have cared for me and that caring has been a powerful experience.

APPENDIX A

Research Information Sheet for Participants

"Caring Experience: A Nursing Faculty's Exploration"

Watson (1988) describes nursing as

> The profession that has an ethical and social responsibility to both individuals and society to be the caretaker of care and the vanguard of society's human care needs now and in the future (p.32).

Benner (1991) describes caring as being

> learned experientially because it is dependent on recognition of salient ethical comportment in specific situations located in concrete specific communities , practices and habits (p.2).

The nursing faculty at North Island College are implementing a new curriculum in September 1993. The curriculum is organized using "caring" as a metaconcept and stresses the importance of reflection in becoming a caring professional. The opportunity to reflect on individual and collective caring journeys becomes important as the faculty are familiar with teaching caring using a behaviorist model and have not explored the concept of caring together.

My research proposal involves exploring, with faculty through individual semi-structured interviews, their caring histories. As well, opportunity will be provided for sharing through a workshop format organized loosely around the themes identified in the interviews. Using various individual and group activity formats, the workshop is intended but not restricted to focusing on the sharing of caring histories, the identification of challenges to caring, and the formulation of strategies to assist nursing students in their development as caring professionals.

As well as participating in the interviews and the workshop, research participants will be asked to review their interview transcripts to suggest desired changes and corrections. Participants will also be asked to review the individual and workshop theme constructions to ensure their views are represented in the research.

Other Research Information

- You will be asked to sign a research consent form. By doing so you are acknowledging the following:

1. that you understand the procedures to be used in the research
2. that you understand you may register a complaint regarding the research with the University, if so desired
3. that you understand you may withdraw from the research at any time
4. that you agree to participate by being interviewed and taking part in the faculty workshop.
5. that you understand that you may receive copies of the results of the research by requesting them from the researcher
6. that you understand you will receive a copy of the consent form
7. that you understand you will receive a copy of the subject feedback form

- Anonymity will be assured by changing the names of individual faculty on all documents. A system of codes, maintained separately from the interview transcripts, known only to the researcher, will be used to identify the stories and their actual sources. The interviews will be analyzed using

themes, thereby reducing the likelihood of identification with a particular source. You will also have opportunity to read and suggest changes to the materials developed before they become part of the final research document. When telling your caring stories, you should avoid actually naming people and places or use pseudonyms to assure anonymity. Should you wish to be named and have your contribution to the research recognized, your wishes will be honored in this respect. To ensure confidentiality, all records including tape recordings, transcripts, and computer discs will be treated and stored in a confidential manner.

- Although every effort will be made to ensure anonymity, it cannot be absolutely guaranteed, in that records, by law, can be subpoenaed should a case emerge .

- With your permission, the individual interview will be recorded using a cassette recorder. Should you feel uncomfortable with this arrangement at any time during the interview, the tape recorder will be shut off at your request and pen and paper used instead.

APPENDIX B

Interview Guide for Research on "Caring Experience: A Nursing Faculty's Exploration"

In an effort to gain understanding into how students can be assisted to develop an awareness of caring and its centrality in the nursing profession, I am conducting research involving our nursing faculty. I will be asking you to explore with me how your awareness and practice of caring has evolved over your career, and to consider factors that have enabled you to practice nursing in a caring way, those factors that have been challenges to caring, those experiences that have been "paradigm" cases for your understanding of caring, and strategies that helped you learn about caring.

This list of questions is a guide only. During the interview, you are welcome to address the issue in any order or format that is comfortable for you and of assistance in exploring caring from your perspective.

Questions Guide

- Think back to your student days and describe how you perceived caring prior to entering your school of nursing.

- Can you remember how the nursing program was designed to assist you in developing an awareness of caring? Did it achieve this?
- Can you tell me about experiences as a student, positive or negative, that were important in your development as a caring professional?
- Now consider your career as a nurse in any of the four practice domains : practice, administration, teaching, or research. Describe how your attitude to caring has evolved since graduation. Use stories from your practice to illustrate if helpful to you.
- There are many factors in the workplace, the community and in our personal lives that affect the ability to care. Can you describe those that have been a positive influence on your caring ability?
- Now think about factors that have been a challenge to your ability to care.
- What strategies have been helpful in dealing with these challenges?
- You have described your journey as a caring professional, can you now think about what you see as essential for a nursing program to consider in assisting students to develop an awareness of caring and its importance in the profession?

Demographic Information Form

Thank you in advance for completing this form. The information provided will be used in the research on "Caring Experience: A Nursing Faculty's Exploration" to report general demographic information about participants.

AGE (please circle): 25-30 31-35 36-40 41-45 46-50 51-55 **LENGTH OF TIME TEACHING AT NIC:** _____

Nursing Employment History **Education**

Area of Responsibility	Length of Time	**Entry/Initial Education**	Province/State	Date Completed
DIRECT PATIENT CARE	//////////////////////////	Diploma in Nursing		
Medical/surgical		Baccalaureate in Nursing		
Critical Care		**OTHER EDUC IN NURSING**	Specify Prog as appropriate	//////////////////////
Operating Room		Master's Degree in Nursing		
Ambulatory Care		Baccalaureate Degree in nsg		
Emergency Care		Post-basic Certificate/diploma		
Maternal/newborn		**EDUC OTHER THAN NSG**	//////////////////////	//////////////////////
psychiatric/mental health		Master's Degree		
Pediatrics		Bachelor's Degree		
Geriatrics/Gerontology		Post basic Certificate/diploma		
Occupational Health		Other		
Community Health		**CURRENT EDUC. PROGRAM**	//////////////////////	Date Begun
Home Care		Not currently enrolled		
Other Patient Care		Enrolled in nsg. program		
ADMINISTRATION	//////////////////////	Enrolled in non-nsg program		
Nursing Educ Admin.		Full time student		
Nursing Service Admin.		Part Time student		
Other Administration		**TYPE OF PROGRAM**	//////////////////////	//////////////////////
EDUCATION	//////////////////////////	Master's		
Teaching-students		Baccalaureate degree		
Teaching-Employees		Certificate/diploma		

Table 2: Relating Individual, Workshop and Shared Themes

PARTICIPANTS INDIVIDUAL THEMES							WORK-SHOP	SHARED
Marnie	*Julie*	*Pat*	*Tina*	*Sharon*	*Kim*	*Eppie*	THEMES	THEMES
Paying attention to self	Valuing self	Fit of self with caring	Caring for self	Gaining experience	Making decisions for self	Control of self	Caring for self	Caring for self
Choice for self and others	Valuing the other	Creating space for cared for	Personal choice for self and others	Available to cared for	Promoting personal decision making	Creating relations that promote personal control	Valuing people. Respecting cultural differences	Choice for the Cared For
Caring not "taught" in Nursing School stated in all participants interview transcripts								Caring "not" taught
Awareness of other and their needs	Recognize influences on caring	Becoming competent	Learning to respect other and choices	Gaining experience	Making caring decisions	Learning to make creative decisions	Caring learned through positive experience	Caring learned through experience
Choosing to be uncaring	Not valuing other	Not commited to competent practice	Not caring for self so unable to truly care for others	Not available for the other	A decision not to care	Controlling others	Caring learned through negative experience	Uncaring important
Other aware of her needs	Valued by others	Observing competent caring	Respected by others	Others available and approach-able	Being given responsi-bility	Control being left with cared for	Other being sensitive to needs of cared for	Role Models
Choosing to care	Dealing with influences on caring	Desiring competent practice	Nurse's choice to care	Nurse to be available and an advocate	Nurse to make caring decisions	Nurse to connect and create caring relations		Personal responsib-ility to be caring

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