STUDENT PERSPECTIVES

ON LEARNING ABOUT CARING

DURING A CLINICAL NURSING PRACTICE EXPERIENCE

by

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Abstract

The purpose of this qualitative study was to explore nursing students' perspectives of learning about caring during a clinical practice experience.

Six students from my 1994 spring and summer clinical groups participated in the study on completion of their clinical practice experience. Four students were in the first year of the collaborative nursing curriculum and two were senior students in the nursing diploma program. Face-to-face interviews constituted the primary method of information collection. Students' clinical journals were also photocopied and used to augment interview information. Interviews were thematically analysed and forty-six themes identified.

Analysis of the collected information suggested that students do learn about caring in the clinical practice area. They indicated that experiences of observing others care, of caring for others, and of being cared-for contributed to their developing sense of a caring self. Students also noted a paradoxical nature to learning about caring; that is, caring is often best learned or understood in terms of non-caring.

Information analysis also revealed several common themes within the students' definition of caring. These included recognition of client needs, the difficulty of saying good-bye and time.

The results of the information analysis suggest some implications for nurse educators. The careful choice of clinical placements and the education of staff nurses regarding their influence on student nurses is critical. As well, students

require time to reflect about their clinical experience in order to integrate the experience with their developing sense of a caring professional. Further exploration of the many tensions and contradictions raised by the students related to the paradoxical nature of caring is also required.

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Chapter I

Introduction

Caring is the philosophy that imbues the practice of
nursing while also being the manifestation of nursing care.
It is a way of being, a way of knowing, and a way of doing.
Caring is the primary work of nurses. It is thoughtful,
deliberate and active work based in human interaction (Bevis
& Watson, 1989; Watson, 1988). Nursing students are engaged
in the process of learning about the work of nurses. That
learning takes place in several venues - the classroom, the
laboratory and the clinical practice area. This document
represents the account of six nursing students' perspectives
on learning about caring during a practice experience in a
clinical area.

Context of the Problem

Traditionally grounded in empiricist and behaviourist
philosophy, nursing education has focused on the medical
model of diagnosis and cure. All facets of nursing care
were reduced to specific measurable, behaviourial
objectives. For example, students were required to
demonstrate caring behaviours by maintaining eye contact
with clients and drawing privacy curtains. Nursing care
objectives usually focused on identifying disease symptoms,
understanding the medical care plan, and performing
technical skills competently. Focused on the scientific
paradigm, nurse educators did not deny caring as the primary

work of nursing; that work was, however, subjugated to scientific and medical standards of technology and cure (Bevis & Watson, 1989; Bishop & Scudder, 1991; Doering, 1992; Hagell, 1989; Watson, 1988). Seeking acceptance within the scientific community, objective knowledge was considered of greater value than knowledge gained through the subjective experience of caring for others. Nursing practice, education and research, therefore, focused on the development of an empirical knowledge base (Carper, 1978). Skilful, caring nursing practice was neither investigated nor documented (Benner, 1984). Caring was equated with technical skill as well as technological and scientific knowledge. Consequently many students and practicing nurses believed that caring involved a standardized algorithmic or automatic response to a set of physical problems through the performance of instrumental tasks. Individuals became objects of care rather than individuals experiencing health challenges (Bevis & Watson, 1989; Bishop & Scudder, 1991; Chipman, 1991; Hagell, 1989; Noddings, 1984; Roach, 1992; Watson, 1990).

As a practicing nurse on acute medical and surgical units I was aware of the deficient caring relationship between clients and nurses. I witnessed instances of individuals being medicated, turned and positioned, and receiving assistance with basic physical hygiene, without being acknowledged. Inadequate individualized care provided

further evidence of ineffectual caring relationships between nurses and clients. All clients received the same care, whether or not appropriate. Caring was reduced to a formula consisting of set tasks and interactions. Little attention was given to the "whole" individual. An example may be taken from personal experience. An older woman was physically restrained under the guise of caring and ensuring client safety.

> One night while making rounds I noticed a bedside rail propped up on a chair. When I inquired of the nurse caring for the client, I was informed that because this was an older individual it was necessary to raise the siderail to prevent the client from falling out of bed. The rail was broken, however, and to be kept in the raised position has to be propped on a chair. I returned to the client, and asked her how long she had been in hospital. She stated she had come in that evening due to abdominal pain. I asked from where, and she replied 'home'. I asked how she managed to get around at home and she stated with her 'walker'. I took the bedside rail down and put the walker where the client could reach it, and left the bathroom light on. The nurse looking after the patient told me I would be in trouble if the patient fell. (Pierson, personal experience)

The nurse caring for this individual believed her action was caring and instituted in the client's best interest. Yet the automatic raising of the side rails detracted from the client's autonomy, sense of personhood, and clearly was not based on an accurate assessment of the individual. Socialization of students into this technical and automatic mode of thinking generally occurs quickly. Usually by the completion of a two-year diploma nursing education program,

novice nurses are well entrenched in this type of mechanical thinking and accompanying behaviours.

Some authors suggest that the present difficulties in nursing care delivery are in many ways attributable to the established curricular approach to the teaching of nursing care (Bevis & Watson, 1989; Bishop & Scudder, 1991; Chipman, 1991; Jenks, 1993; Roach, 1992; Watson, 1990). Nurses have generally been educated according to the "banking concept of education" (Freire, 1979, p. 66). Necessary information is regularly deposited, by instructors, into students' minds. In this model, the instructor assumes responsibility for identifying necessary content and the flow of information tends to be unidirectional. Certainly, under the constraint of time, and the volume of medical science and biological material deemed necessary to cover, the banking model allowed for the most efficient use of resources. The consequences of the banking model are nursing students who have not been encouraged to analyze or reflect on the material they were learning. What may be of greater import, however, is the subtle message students received about power, and the relinquishing of control to others (Bevis & Watson, 1989; Hedin & Donovan, 1989). Instructors were assumed (by the students and sometimes by the instructor) to have all requisite information and power. Students were required to gather, interpret and understand information as intended by the instructor. The result is a group of

professionals who have not been encouraged to critically
analyze or reflect on their position, or the position of
those for whom they advocate.

Challenges and Possibilities

The challenge is to emancipate or liberate nursing
education from the "restraints of empiricist/behaviourist
models" (Bevis & Watson, 1989, p. 1). It is suggested that
this may be best accomplished by reclaiming caring as the
moral imperative for nursing. The notion and development of
the 'caring curriculum' has been generated and developed
primarily by four nursing theorists, E. Bevis, J. Watson,
C. Tanner, and J. Murray. Bevis and Watson (1989)
collaborated on a text that has become a guide for nursing
curricular change in both Canada and the United States. In
British Columbia this curriculum is being implemented
through a collaborative effort between the University of
Victoria, Okanagan University College, University College of
the Cariboo, Kwantlen University College, Malaspina
University College, Selkirk College, Camosun College, North
Island College, Langara College, and Douglas College.

The essential tenet of the proposed change is to view
curriculum as "the interactions and transactions that occur
between and among students and teachers with the intent that
learning occur" (Bevis & Watson, 1989, p. 5). Conceptually
the curriculum moves from the notion of the teacher

possessing all necessary knowledge to the teacher as meta-learner and meta-strategist.

> The mandate is to shift from a focus on training to education, from technique to understanding, from strict content to critical clinical decision making, from product line thinking to value-based human caring education for an educated person, as well as an educated values-driven professional (Bevis & Watson, 1989, p. 39-40).

The changes encourage the development of curricular activities that move away from the maintenance learning of rules and principles that may be universally applied to every situation. In its place is an innovative approach founded on the concepts of context/culture, personal meaning, time/transitions, ways of knowing, and peoples' experiences. Within the frame of this curriculum, teaching/learning is a practice driven, dynamic interaction that involves the use of small group work, simulations, case studies and written journals. Both subjective experiences and objective rationality are valued in the teaching/learning process.

Central to the development and implementation of the curriculum is the idea of caring as a moral imperative. Caring as one of the meta-concepts focuses the curriculum on developing the individual's sense of an ethical self, responsibility and duty. It is a fundamental assumption that the moral education of nurses will produce a positive change that will affect the nursing profession, society and humanity (Bevis & Watson, 1989; Watson, 1988).

Students involved in the caring curriculum focus on the holistic care of individuals in a variety of practice settings. The inherent attributes of caring become the focus of nursing care. Virtues such as compassion, empathy, engagement, presence, and support are employed with competent technical care. The relationship between the individual experiencing a health challenge and the nurse becomes paramount and forms the milieu for healing and health promotion (Bevis & Watson, 1989; Roach, 1992).

Evolution of the Question

Four types of curricula - legitimate, illegitimate, hidden and null (Bevis & Watson, 1989, p. 74) have influenced the nursing education process. Traditionally, the legitimate, or "curriculum-as-plan" (Aoki, 1986, p. 4) has been guided by empiricist/behaviourist paradigms. Consequently, educational aims have been expressed as measurable, observable behaviours and teaching/learning activities have focussed on these behaviours. Nursing care was discussed as a technical response to a biological need or the medical care plan. In this paradigm, behaviourial objectives frequently created a gulf between the students, the teacher, and the experience of caring. The objectives ensured that teachers viewed situations in prescribed ways. There was no allowance for a teacher's intuitive sense of students' abilities. The illegitimate curriculum comprised of notions such as "caring, compassion, power and its use,

ethics, politics in health care settings, and being accountable and responsible" (Bevis & Watson, 1989, p. 75) was not consistently explored or examined by all nurse educators. Concepts within the illegitimate curriculum tended to be learned serendipitously. The hidden curriculum involved the surreptitious socialization of students into the mores of the nursing community. Students essentially learned the language, mores and philosophy of nursing by talking, listening and watching working nurses during clinical practice experiences (Parker, 1990). Unfortunately, many working nurses educated in the traditional behaviourist paradigm often personified rote and technical behaviours and promoted students' adeptness at caretaking rather than caring (Bevis & Watson, 1989; Bishop & Scudder, 1991; Noddings, 1984; Rawnsley, 1990). The null curriculum of "humanities, liberal arts, critical thinking, inquiry, creativity, and the full range of human intellectual capacity" (Bevis & Watson, 1989, p. 76) constituted an unrealized goal for many nurse educators.

The refocusing of nursing education curricula on the centrality of caring is an attempt to relieve the tension among the four types of curricula (Bevis & Watson, 1989) and re-engage the epistemology and ontology of caring within the practice of the nursing profession.

The advent of the caring-based curriculum renewed, for me, a sense of hope about creating change in our nursing

care environments. Anxious to truly understand the tenets
of the curriculum I began graduate work in the Faculty of
Education to explore the philosophy and perspectives
underlying the new nursing curriculum. As I have come to
understand the philosophy of the curriculum in greater
depth, my commitment to the development and implementation
of this curriculum has increased and strengthened.

Within the abundance of published material related to
caring, little specifically relates to caring and the
teaching/learning process. Traditionally nursing education
literature focused on identifying strategies to assist
students in successfully achieving objectives. It is only
recently that authors have begun exploring the notions of
caring and nursing education. Most authors writing in this
area tend to focus on delineating students' perspectives of
caring teacher behaviours (Halldórsdóttir, 1990; Hughes
1992; Miller, Haber & Byrne, 1990; Nelms, 1990; Nelms, Jones
& Gray, 1993). While these studies provide some sense of
the nature and importance of caring within the
teacher/student relationship, there is limited published
research on nursing students' perspectives on learning about
caring during their educational process. Through this study
I propose, therefore, to begin a dialogue with students that
may assist in constructing an understanding of students'
perspectives on learning about caring specifically related
to their experiences during clinical practice.

Purpose

The aim of this study was to explore the students'
perspectives on the ways they learned about professional
human caring relationships within the context of a clinical
practice experience. The intent was not to examine the
student-teacher relationship, though I believe that a caring
pedagogical relationship with students is critical to the
development of their ability to care in a professional
relation. Rather, the intent was to focus on students
relations with clients; to examine their responses and their
development of a professional caring relations within the
context of caring for others.

The development of a caring relation with others is
critical to the practice of nursing. Caring, within the
parameters of nursing practice, involves developing a
connected relation with clients. That relationship is
founded on trust and a sense of safety. A caring
relationship then has the potential to facilitate
substantive dialogue and foster self-awareness, growth and
healing. Students, in the clinical area as beginning
professional caregivers are expected to develop caring
relations with clients. The ways students learn about
caring relations when in the clinical area and the types of
relations that students form with clients were the ideas I
considered when developing this study. Consequently, this
work considers student perspectives about the ways they

learn about caring in the clinical practice area,
specifically related to their interactions with clients.

Research Approach

A phenomenological mode of inquiry was selected as
the approach for this investigation. The essential
assumptions of phenomenology that guided this study included
a holistic perspective which facilitated examination of the
participant's "being-in-the-world" (Heidegger, 1962, p. 78);
subject-object inseparability which allowed for the co-
creation of meaning about caring; the lack of distinction
between cause and effect which acknowledged the
collaborative relationship between myself and participants;
and truth and reality which assumes that each person's sense
of reality is constructed and therefore all statements of
truth are legitimate (Lindsey, March 1995, p. 1-31). This
perspective facilitated exploration of the students'
contextual reality and the development of a shared meaning
about caring (Merriam, 1988; Rather, 1992; Walters, 1994;
Watson, 1988).

Information collection was approached in two ways. On
completion of their clinical rotation students in my
clinical groups, during the 1994 spring and summer
semesters, received a letter of invitation requesting their
participation. Those who agreed to take part, participated
in a face-to-face audio-taped interview. In addition

participant's clinical journals were photocopied and reviewed.

Interviews

Audio-taped interviews, guided by a thematic schedule, were conducted with the students. Students received a type-written copy of their transcript for reflection and verification. Approximately three weeks later, students were contacted to determine if they would like to schedule a second interview for the purpose of clarifying any information. When contacted, the students indicated that the transcripts accurately illustrated their thoughts.

Journals

During the semester all students in my clinical groups maintained written reflective journals. Journal writing, in this instance, captures the stories of novice nurses in the process of defining themselves as professional caring beings. It is a means of assisting students to determine the meaning and significance of experiences and provide them with an opportunity to reflect and integrate knowledge with experience (Atkins & Murphy, 1993; Hahnemann, 1986). In some instances the reflective process was guided with learning activities related to caring. Students who agreed to participate in the interviews also agreed to allow their clinical journals to be photocopied. This information was used to augment information collected during the interviews.

Definition of Terms

Student refers to any student nurse, in any semester, of either the diploma or the baccalaureate nursing program at Langara College. Nursing practice experience or clinical practice experience designates the six, seven, or thirteen week clinical rotation in which a student nurse participates as a member of a clinical group. Clinical groups are composed of six to thirteen students completing one clinical rotation together. The number of students in a clinical group is dependent upon the total number of students in a semester as well the clinical expertise of the students. Clinical journals are the documents maintained by the students as a component of their clinical practice experience. Nursing care refers to any cognitive, affective or technical action implemented within a professional relationship by a Registered nurse or a student nurse.

Limitations

This investigation focused on the exploration of the thoughts and feelings of a group of nursing students regarding learning about caring during a clinical practice experience. This written work records that exploration constructed from the conversations that occurred between the students and myself. As such, this information adds to the understanding of the phenomena of learning about caring (Connelly & Clandinin, 1990; Guba & Lincoln, 1989; Marshall & Rossman, 1989).

Some may suggest that the self-selection of students is a limitation. It is possible that an unique group of students volunteered to participate. Information gained through the interviews and from the journals, however, provided a rich and thick description of the phenomena of learning about caring and may be considered transferable as it is likely that students in comparable programs will identify similar experiences and responses to those experiences.

Thesis Organization

Chapter one is an outline of the context of the problem and purpose of the study. Chapter two is a review of salient literature related to teaching/learning about caring. Chapter three is an account of the research approach and incorporates information regarding the students and their participation, information collection and analysis. The fourth chapter is a discussion of the students' perspectives related to learning about caring. In the fifth chapter some implications for nursing education and further research are suggested.

Chapter II

Literature Review

There are certain commonalities between the disciplines of education and nursing. Each is an intensely human endeavour profoundly affecting individuals' quality of life; each deems caring to be a significant ideal; and each is generally considered women's work (Bevis & Watson, 1989). Presently, within both disciplines there is keen interest in the phenomenon of caring and its implementation in daily pedagogical or nursing practice. This chapter is a review of the literature related to caring and the teaching/learning process considered salient to this investigation.

The Curriculum

The notion that "the interactions and transactions that occur between and among students and teachers with the intent that learning occur" (Bevis & Watson, 1989, p. 5) is the foundation and guiding principle for all teaching/learning activities in the baccalaureate nursing curriculum. Implementing this curriculum has involved a fundamental departure from conventional approaches to nursing education.

Historically, nursing curricula were steeped in content driven by the positivistic medical paradigm. Nursing care was discussed in terms of technical responses to biological systems or medical care plans. The delivery of care was

learned through an empirical mode of knowing, the nursing process. The process, founded on the traditional scientific method involves a deliberate, systematic and neutral approach to client care. Empirical data are collected and analyzed. Based on the analysis, the nurse makes decisions regarding interventions. Measurable, behaviourial goals are then set for clients indicating the time frame for achievement. The nursing process focuses on the disease process, defining clients' problems, and directing the actions of the nurse. The primary assumption governing the use of this model is the possession by the nurse, of the necessary knowledge accompanied by the ability to execute the actions required for clients' healing and wellness. Though the care plans, in theory, are validated with clients in an attempt to involve individuals in their care, the process does not truly allow for people to be in control of their health or the situation.

Students learned the nursing process at the beginning of their educational program and were required to demonstrate effective and efficient use of the process both in class and in clinical practice. Reliance on this rational, objective problem-solving technique, however, has resulted in the maintenance learning of rules and procedures, disease processes and technological interventions (Watson, 1985). Dependence on this empirical

mode of knowing has also led to caretaking practices that are distant from the reality of clients.

> Rules are formulated and the characteristic variation in response to the needs of the cared-for may fade away. Those entrusted with caring may focus on satisfying the formulated requirements for caretaking and fail to be present in their interactions with the cared-for. Thus caring disappears and only its illusion remains (Noddings, 1984, p. 25-26).

The intent of the new curriculum is to graduate "compassionate scholar-clinicians" (Bevis & Watson, 1989, p. 1) capable of employing imaginative, insightful and thoughtful approaches to client problems and issues. Achievement of this aim necessitates integrating the legitimate, illegitimate, hidden and null curricula (Bevis & Watson, 1989). Nursing content generally learned fortuitously in the illegitimate, hidden and null curricula have been moved into the planned curriculum. Content is focused on nursing concepts such as change, chronicity, health, healing, and poverty rather than on biological and medical concepts such as fluid and electrolyte balance, or cell injury and inflammation. This is not to suggest that medical and biological concepts are neglected. Rather, students learn to incorporate information from these notions with nursing knowledge and expressions of clients' experiences, to construct a comprehensive picture and understanding of clients' health and health challenges. Within this paradigm students move from rote, technical thinking and behaviours to thoughtful, compassionate

reasoning and actions, where the living relationship between nurse and client forms the milieu for healing and health promotion (Bevis & Watson, 1989; Roach, 1992).

Actualization of this change in nursing education required a reaffirmation of human caring as a moral imperative essential to the healing process. Consequently, caring permeates the curriculum as a meta-construct. There has also been a simultaneous shift from the empiricist principles of natural science to the phenomenological and relational tenets of human science.

Human Science

It is only recently that the nursing community has begun to accept and value the "contextual, phenomena-centred knowledge" (Doering, 1992, p. 31) of human science, and the practical embodied knowing of expert clinicians (Benner, 1984; Benner & Wrubel, 1989). Currently, there is a movement towards knowing that permits human phenomena to be investigated and understood while valuing the subjective experience (Benner, 1984; Benner & Wrubel, 1989; Watson, 1988). This manner of knowing respects the interaction between individuals and peoples' lived experience of health/illness. Individuals describe health concerns according to their perception of the experience. Nurse and clients together explore concerns in a manner that assists individuals to clarify plans, desires and priorities. The

central modes of knowing in this scenario are

phenomenological and relational.

The shift to the tenets of human science as predominant

modes of knowing requires a concurrent shift in nursing

education. Consequently, the focus of the educational

process is changing from an instrumental maintenance

learning model to a moral-based system focused on

connectedness and caring (Bevis & Watson, 1989;

Watson, 1988).

> This framework accommodates an evolving
> professional consciousness and allows for methods
> that attend to the moral ideals and values that
> are relational, subjective inner experiences,
> while honouring intuition, personal, spiritual,
> cognitive, and physical senses alike (Bevis &
> Watson, 1989, p. 53).

This new framework seeks to facilitate the development of

"scholar-clinicians" (Bevis & Watson, 1989, p. 1) who will

use a variety of methods and resources to explore and

understand individuals' lived experiences and situational

contexts. Consequently, it is necessary to devise and

incorporate teaching/learning methods that will promote

students' development as ethically caring individuals and

skilful clinicians. It is suggested that education in this

moral domain "involves learning how to equip them with the

conceptual tools, the self-respect, and the opportunities to

choose - in specific circumstances - how to do what they

consider right" (Greene, 1973, p. 273). Noddings (1984)

suggested that the teacher as one-caring, meeting students

through the human dimensions of "modelling, dialogue, practice, and confirmation" (p. 175-193), fosters the growth of ethically caring individuals. Bevis and Watson (1989) deemed incorporation of these four dimensions a necessary requirement in instruction about caring.

Modelling occurs when educators "encourage self-affirmation and self-discovery in students" (Bevis & Watson, 1989, p. 55). This is accomplished through the use of active learning strategies and the development of connected relationships in the classroom and in clinical practice. Dialogue is essential to caring-based moral education and creates the opportunity between teacher and students for caring learning occasions. Practice represents the union of theory and practice. It is where dialogue and modelling merge so students may clearly understand caring in practice. Confirmation is a consolidation of the other dimensions and ensures affirmation of the student both as one-caring and as cared-for (Bevis & Watson, 1989, p. 55-58).

Caring

Viewed from a Heideggerian perspective caring is determined to be "primordial" (Heidegger, 1962, p. 238) and the foundation of all thought and action. It is a human way of being "characterized by relatedness to surrounding objects and other individuals, in terms of being concerned with and caring about them" (Flew, 1979, p. 83). Accordingly, caring may be considered a motivating force

within individuals that generates a "response to someone or
something who or which matters (Roach, 1992, p.4). The
central component of caring is therefore, the notion of
connectedness demonstrated by the relation between
individuals.

> Human care can be effectively demonstrated and
> practiced only interpersonally. The
> intersubjective human process keeps alive a common
> sense of humanity; it teaches us how to be human
> by identifying ourselves with others, whereby the
> humanity of one is reflected in the other (Watson,
> 1985, p. 33).

The constituent elements of caring relations include an
active sense of engagement, genuine responsiveness,
presence, reciprocity and the commitment to foster the well
being of another (Benner & Wrubel, 1989; Carper, 1978;
Morse, Bottorff, Anderson, O'Brien & Solberg, 1992;
Noddings, 1984). Caring in this notion is more than a
sentiment of good will towards others. It is an ethical
ideal deeply grounded in our sense of humanness, emphasizing
a dynamic interpersonal relation between individuals and
directing the manner in which individuals meet each other
morally.

Noddings (1984) suggests that it is our desire for
caring (to care-for and be cared-for) and the development of
the caring relationship that motivates moral behaviour. A
desire for caring relations fosters a "state of moral
awareness" (Roach, 1992, p. 63) and generates a sense of
obligation or 'I ought' in response to individuals or

situations. A sense of moral duty then influences the action and feeling of caring.

The conscious decision to be morally committed to the ideal of caring obligates individuals to consistently seek to enhance the ethical ideal to be caring. Central to the enhancement of the ideal are the notions of responsibility and self-awareness (Boykin & Schoenhofer, 1993; Gilligan, 1982; Noddings, 1984; Watson, 1985). Self-awareness is cultivated through a process of reflection and acceptance of "what is there-in-herself" (Noddings, 1984, p. 108), and ensures that the internal dialogue of the one-caring is consistent with the external response to the cared-for. It is the responsibility of the one-caring to know that the response to the cared-for is genuine, honest, and consistent with the ethical ideal of caring.

Transformation of the traditional nursing curriculum to an "educative" (Bevis & Watson, 1989, p. 6) and "caring paradigm" (Bevis & Watson, 1989, p. 7) has compelled significant changes to content and teaching/learning strategies, in both classroom and clinical practice areas. Implementation of these changes is primarily the responsibility of the teacher.

Role of the Teacher

Replacement of the rigid and confining models and data of the positivistic paradigm with a thoughtful, inquiring approach based in human science, necessitates that nurse

educators create and implement a different type of learning environment. The type of change required is described by some authors in terms of a distinction between instructing and teaching (Bevis & Watson, 1989; Eisner, 1985b).

The action of instructing may be considered as a rigid and mechanical approach to curriculum that "maximizes effective control over the content and form" (Eisner, 1985b, p. 181) of what students learn. The instructional environment promotes an atmosphere of passivity devoid of imaginative or critical thought. Teachers in this paradigm tend to be perceived as distant and omnipotent authorities. In nursing education, instructing suggests maintenance of the traditional student/teacher power dynamic by using passive information-giving strategies, in conjunction with medical and biological content. Responsibility for identifying necessary content and ensuring that all students receive similar knowledge and experiences belongs absolutely to the instructor. Students are required only to recall data during examinations or when questioned in clinical practice situations. This type of learning promotes routine and predictable thinking and negates the need for original or critical reasoning. Consequently, students tend to be trained rather than educated.

Teaching is viewed as a more pliant strategy that invites students and teacher to participate in an interactive learning process. Participation of the teacher

in the learning process involves the teacher as co-learner and serves to disassemble traditional notions of power (Freire, 1970; Greene, 1973; Rogers, 1983). The teacher's power, in this model, is portrayed as expertise in content, learning, inquiry and scholarly pursuits, and is used to organize the class in a manner that will support learning (Bevis & Watson, 1989; Greene, 1973). The alliance or "specialized caring relation" (Noddings, 1984, p. 175) consequently formed between teacher and students is both a pedagogical and a caring relationship. A cyclical and rhythmic relation, it evolves from a sense of knowing students in a manner that is "simultaneously engaged and reserved, close and distant" (van Manen, 1986, p. 18-19). This pedagogical sense of knowing students involves more than recognition of the strengths and weakness of novice nurses. It entails an "attentiveness" (Elbaz, 1992, p. 426) and sentient perception of each students' uniqueness that captures a sense of understanding both the student, and the meaning of the situation for the student. This "pedagogical perceptiveness" (van Manen, 1991, p. 534), not unlike expert nurses' knowing of clients (Tanner, Benner, Chelsa & Gordon, 1993), is nourished through day-to-day experiences with students and forms a "tacit, intuitive knowledge...learned in subtle ways by attuning ourselves to the concrete particulars of situations" (van Manen, 1991, p. 534). Teachers seek to know students patterns of response to

teaching/learning occasions, as well as know each student as a person. The active engagement of students and teacher in a caring relation and as co-participants in learning forms the base by which teachers come to know their students.

> I do not need to establish a lasting, time-consuming personal relationship with every student. What I must do is to be totally and non-selectively present to the student - to each student - as he addresses me. The time interval may be brief but the encounter is total (Noddings, 1984, p. 180).

The perceptive attunement of the teacher to the student creates a dynamic learning environment (van Manen, 1986). Consequently, it is the 'knowing' of student that fulfils an ethic of care and responsibility. For nurse-educators this knowledge is learned during both classroom and clinical practice experiences with students.

Student-Teacher Interactions

Within nursing education energy is directed towards the development of learning activities and teacher-student interactions that will promote students' abilities to respond caringly and effectively to client needs (Bevis & Watson, 1989). The interactions that occur between teacher and students, within the curriculum, are intended to foster the development of students as caring individuals and promote learning. The nature of the relationship between teacher and students and its effect on teaching/learning has been examined by several authors.

Hughes (1992) interviewed ten junior nursing students from differing types of nursing schools to discover how students perceived "the climate for caring" (p. 61). All participants were female, white, and full time students in beginning level nursing courses. None of the participants possessed a license to practice nursing. The ages ranged from 21-46 years and three held bachelor's degrees in another discipline.

Data analysis indicated that faculty sensitivity and responsivity to students' feelings of stress and anxiety were considered by participants to be a component of a caring atmosphere. Other facets of the caring atmosphere included providing safe opportunities for the expression of opinions and concerns, and placing a high priority on meeting students' needs (Hughes, 1992).

Halldórsdóttir (1990) "explored the essential structure of a caring and uncaring encounter with a teacher, from the perspective of the recipients of nursing education" (p. 96). Focused on the relationship between teacher and student, specific elements of the teacher's approach (professional competence, genuine concern, positive personality and professional commitment) coupled with mutual trust and a professional working relationship created positive student perceptions related to caring within the teacher-student dynamic. Participants identified the components of a professional working relationship as initiating attachment,

mutual acknowledgment of personhood, professional intimacy,

negotiation of learning outcomes, student goal-directed

work, separation and keeping a respectful distance

(Halldórsdóttir, 1990).

Nelms (1990) found similar results when he interviewed

seventeen baccalaureate nursing students. The purpose of his

study was to investigate the lived experience of nursing

students. Students indicated that the clinical practice

experience and the relationship with the clinical teacher

was paramount. Many of the qualities of the teacher-student

relation identified by Halldórsdóttir (1990) were reiterated

by Nelm's participants. A similar notion of a professional

relationship promoting positive caring experiences with

students is discussed by Rawnsly (1990) through the concept

of "instrumental friendship" (p. 47) which she describes as

a "metaphor for the caring connection" (p. 47). It is her

view that the substance of instrumental friendships emerges

as caring and facilitates students' experiences of being

cared-for. Students' experiences of being cared-for in the

teacher-student relation promote their sense of being able

to care-for others. Halldórsdóttir (1990) and Nelms et al.,

(1993) expressed a similar sentiment in their results.

Miller et al. (1990) conducted a qualitative study

exploring the "phenomenon of educational caring by asking

students and teachers to recall and describe an interaction

involving caring in the teaching-learning process" (p. 126).

Interviews were conducted with six faculty and six senior nursing students. Four major and parallel themes emerged from analysis of the data: "holistic concern or philosophy, teacher ways of being, mutual simultaneous dimensions of intimacy, connectedness, trust, sharing and respect, and student ways of being" (Miller et al., 1990, p. 128-129). Students identified that the response of teachers to their individual personal and academic needs as a "holistic concern" (p. 130) was a basic caring quality; faculty indicated that they approached students with a "holistic philosophy" (p. 130). Ways of being for teachers and students focused around the development of a supportive climate determined to be empowering, promoting growth and hope. Caring teaching-learning situations were based on a sense of reciprocity, mutual trust and respect. The result was a sense of intimacy and connectedness. These findings are similar to those reported by Halldórsdóttir (1990) and Hughes (1992).

The relation between teacher and students form the basis for creating a learning environment that enhances students' understanding and development as a caring individuals. Caring cannot be taught by introducing content and a set of rules to students. It is learned by experiencing caring practices between teacher and students (Benner, 1984; Tanner, 1990) in a supportive and sensitive environment.

The Learning Environment

Caring pedagogical relationships provide the foundation for learning environments that permit students to explore and develop their caring practice. Construction of this type of learning milieu may be considered as an aesthetic enterprise that constitutes the "artistry of teaching" (Eisner, 1985b, p. 183). Aesthetic experiences involve the crafting or production of a form which is the result of human thought and action. There is also a shared experience of the form during its crafting as well as upon completion (Eisner, 1985a). The relation between teacher and students may be considered one type of aesthetic form. The crafting of an environment that "welcomes exploration and risk-taking and cultivates the disposition to play...with ideas...to throw them into new combinations, to experiment and even to 'fail'" (Eisner, 1985b, p. 183) may be considered another aesthetic form. Characteristics of such a learning atmosphere entails more than a rational, cognitive or technical approach to the understanding of content. It also engenders a sense of community that supports members in their struggle to understand and find meaning in their experiences and the experiences of others. This type of learning climate requires participation of both teacher and students in dialogic interactions.

There is of necessity then, a multivocality to the classroom, lab and practice settings that suggests no

"single voice in the classroom - including that of the professor - assume[s] the position of centre or origin of knowledge or authority" (Ellsworth, 1989, p. 310). Emphasis is placed on the formation of a dialogic and dialectic learning community that permits teacher and students to function as co-learners in the exploration of concepts and information. The teacher needs to be a participatory member of the community to ensure the "full and open interaction of the members" (Rogers, 1983, p. 100) that stimulates creative, imaginative and thoughtful approaches to client concerns and issues occurs.

The artistic quest of the nursing teacher is to promote the development of this inquiring educative community, both in the classroom and the clinical area. There is a significant difference between the classroom and the clinical practice area in terms of learning environment and at times, intensity of teacher-student relationship. Consequently, each learning environment will be discussed separately.

The Classroom/Laboratory Environment

Bevis and Watson (1989) suggested that creation of an inquiring educative community is facilitated by devising "learning episodes" (p. 223) consisting of three elements - "information, operation, and validation" (p. 223). All three elements must be present and may function simultaneously or independently. These learning episodes

are utilized in the classroom/laboratory situation to encourage students' thinking about concepts related to client care and promote the development of constructed knowing.

The information phase is often passive and entails the acquisition of data. Information may be gathered by reading, watching a movie or instructional video, using a computer assisted instruction program or listening to an audio-tape. This stage involves nursing students in the collection of information related to human functioning.

During the operative phase students are actively engaged in imaginative and thoughtful enterprises. This is not to suggest that educators' involve students or themselves in frivolous diversions or abdicate their responsibility "to train the intellect" (Noddings, 1984, p. 173). Rather activities need to focus on "extending ourselves imaginatively" (Egan, 1992, p. 60) into the reality of individuals involved in health and healing. Stimulation of the imagination assists teachers and students to consider possibilities and so engage in creative and critical thinking about client care and health care delivery issues that encourage the development of constructed knowing.

Evaluation takes place during the validation phase. Validation is considered a critical component of every learning episode and may be accomplished in a variety of

ways including teacher, peer or self evaluation. Validation allows for the acknowledgement of growth and potential and provides a mechanism by which teachers may reinforce and strengthen students' developing caring ideal.

Creation and development of a respectful and receptive learning community entails more than the efficacious development of learning activities. Active and equal participation of teacher and students is also required. The teacher is actively and equally occupied with students as both a co-learner and an expert learner. In this role, it is the responsibility of the teacher to "raise questions that require reading, observation, analysis, and reflection upon patient care" (Bevis & Watson, 1989, p. 174) that will promote praxis. And it is through these activities, as well as the participation of teacher and students in a caring dialogic relation that the development of constructed knowing is facilitated.

Constructed knowing as presented by Belenky, Clinchy, Goldberger and Tarule (1986) is considered by Bevis and Watson (1989) to be essential to the development of critically-thinking, socially responsive scholar-clinicians. Constructed knowing assumes that students blend information from external authority, subjective understanding, objective procedures and the voices of self and others to create a personal way of knowing that values context and relation (Belenky et al., 1986). The development of constructed

knowing requires the participation of each subjective voice in the classroom relation. It is the articulation of thoughts and ideas with others in a supportive caring environment that aids the struggle to find meaning in personal experiences and the experiences of others. Interactive activities such as dialogue, debate, story-telling and simulations are some of the strategies considered useful during this phase to promote constructed knowing.

The use of these strategies employs the oral tradition of the nursing profession "to inspire, mentor, inform, or caution novices" (Heinrich, 1992, p. 141). The many stories nurses have about clients, events and circumstances provide a rich and descriptive base of information.

As an expert learner the teacher also has a duty to direct, guide and critique students' activities to encourage further reflection and remediation, and promote the development of students as expert learners. These goals require a supportive trusting atmosphere. Community members must be willing "to become vulnerable and then to exploit that vulnerability in order to acquire knowledge and skills that may be mobilized in the acquisition of understanding" (Gardner, 1991, p. 243).

Participation in this type of dialogic community can be difficult for adult students. Most students in the nursing program have been schooled in educational systems that

demand one right answer. The correct answer has been a requirement for progression throughout the students' scholastic lives. It can also be difficult for many teachers educated in traditional paradigms, to relinquish control regarding content. There exists, therefore, a tension between the learning environment and the participants. The political constraints of the educational system heighten the tension as students are still required to achieve a certain academic level for progression.

Reconciliation of this tension between teacher as evaluator and teacher as co-learner/expert learner is a difficult issue. Noddings (1986) suggests faithfulness to the caring pedagogical relation as one way of mediating this tension.

> ...fidelity is never given first to either self as individual or to institution, but to the others with whom we are in relation and to the relations by which we are defined (Noddings, 1986, p. 501).

As educators, Noddings (1984/1986) proposes that our first duty is to the student-teacher relation. Fidelity to that relation ought to guide our thinking and decision making.

It may be somewhat simplistic, however, to consider the pedagogical relation in nursing education as a dyad, for a third person, the client, is always involved. While nurse educators care about those whom we teach, we must also care about what is learned and the standard to which it is learned. Nurse educators have a societal duty to ensure that clients are provided safe, competent compassionate

care. Students must demonstrate minimum standards of acceptable nursing practice. There is for the teacher, therefore, a constant tension between the equalitarian and emancipative model of nursing education being promoted and the need to ensure that students possess a minimum standard of knowledge and skill.

The Clinical Environment

The clinical practice setting provides a forum for students to integrate the information and skills learned in the classroom/laboratory. It is also the area where students combine the role of student and novice professional nurse. This blending of roles within the clinical practice setting is perceived as demanding and stressful by both teacher and students (Hughes, 1992).

Caring, in the clinical environment is often learned by watching others. Students observe clinicians on the unit, their teacher and their peers. As the published literature indicates (Chipman, 1991; Nelms et al., 1993) students are adept at identifying both caring and non-caring behaviours. Consequently, their observation on the clinical units assist them to construct a personal understanding of caring. Several authors have examined this phenomenon of watching others or modelling. Nelms et al. (1993) completed an investigation focusing on modelling as a method of teaching caring. One hundred ninety-two senior and junior students from diploma and baccalaureate programs viewed a video-taped

scenario of a clinical situation in which an intravenous was being discontinued. Participants completed a two page open ended questionnaire after watching the video. Data analysis generated three broad categories - "connection, relationships, and caring" (Nelms et al., 1993, p. 21). Within the category of caring, three themes, "caring and time, caring and communication, and caring combined with the physical and emotional" (Nelms et al., 1993, p. 22) were identified. Findings indicated that students learn about caring through relationships with teachers, clients, staff, peers and self, and that the ability to care for others is nurtured through these relationships.

Using a grounded theory approach Davis (1993) conducted interviews with six students selected from a first year diploma nursing program. The purpose of the study was to determine if "the observation of clinical models lead students to discover knowledge embedded in clinical practice?" (Davis, 1993, p. 635). Analysis of the information suggested that students readily identify appropriate and inappropriate nursing care practice. Information analysis also suggested that students' view of practitioners alters with professional maturity. Students in the beginning of their nursing experience tended to view clinical models as "people who provide care and interact with clients in positive and negative ways" (Davis, 1993, p. 631). Following the second clinical experience, students

saw the interactions with the clinical models extending
beyond the client to include the students and other health
care team members. At the completion of the third clinical
experience students viewed the clinical models as "creative
carers and trusted friends" (Davies, 1993, p. 632).

Miller et al., (1990) also discussed the importance of
modelling. The authors suggested that students' learning
experiences are maximized when caring behaviours are
modelled by faculty.

Chipman (1991) completed interviews with twenty-six
second year diploma nursing students regarding their
perceptions of caring and noncaring incidents. Data
analysis indicated that students identified caring nursing
behaviours as "giving of self, meeting clients' needs in a
timely fashion, and providing comfort measures for clients
and their families" (Chipman, 1991, p. 172). Behaviours
identified by students did not involve the technical
application of skills but rather focused on humanistic
elements such as compassion and empathy. It is of interest
that while students identify caring behaviours as those
which support individuals in their humanness, clients often
identify caring behaviours as technical skills (Gooding,
Sloan & Gagnon, 1993; Larson & Ferketich, 1993). It must be
noted, however, that often studies which examine client
perceptions of caring are structured to focus attention on
instrumental tasks.

Modelling is a powerful way that students learn about caring and nursing care delivery. While they are watching others, they are also caring for clients within their own assignment. Most students have little or limited exposure to clients with health challenges and feel vulnerable when confronted with the immediacy, intimacy, and sublimeness involved when caring for others. They witness a wide spectrum of intense human emotions and physical conditions. Initial reactions to some of their experiences also encompass a broad range of human emotion. It is at this time that a caring pedagogical relation with students is imperative. Students need to rely on the teacher to support and guide them. Participating with students in these experiences fosters a sense of closeness between teacher and students. Caring, in this milieu is often portrayed between teacher and students in a glance, a touch, or a smile. It is also enacted by adjusting voice tone and tempo, and by modifying questions and explanations to accommodate individual students' needs (Eisner, 1985b). These gestures represent an attempt to consciously coexist with students by creating a sense of their being seen, known and ultimately of being cared-for (Greene, 1973; van Manen, 1986). It is this sense of being cared-for that provides students with the support and strength to care for others.

The circumstance also provides opportunities to truly know students as unique individuals; to be aware of their

patterns of thinking, action, and reaction. Over time, similar patterns of experience add to the teacher's knowing and understanding of students' common issues and expectations (Tanner, et al., 1993). This practical knowledge, often ineffable and intuitive, tends to guide decision making regarding students. In the clinical area this subtle and practical knowing of students frequently surfaces as an understanding of students' capabilities in terms of choosing client situations as learning experiences.

In the clinical area there are clearly domains which must be blended. Students are incorporating the role of student with that of novice nurse. They work intensely, applying newly-learned concepts, attitudes, and actions. Clinical teachers must combine the roles of teacher, nurse and evaluator. Clinical teachers have a responsibility to their students and the students' learning and they also have a responsibility to clients. They must ensure that students are engaging in safe and competent nursing practice. While attempting to generate a safe and supportive environment for students it is important that clients also be safe and supported. There is, therefore, a tension created as these spheres of teacher, nurse, and evaluator are blended. The mediation of some of this tension occurs through caring pedagogical relationships between students and teacher.

The primary aim of nursing education is the development and enhancement of caring individuals. The ethic of care

elevates caring to the level of moral action. The commitment to ethical caring - to be one caring and to be cared for - involves connection, mutual sharing and participation with another. Within the context of nursing practice, ethical care is provided when the nurse is present and engaged with clients. Energy is directed toward understanding the clients' needs and promoting their autonomy. Caring actions are focused on advancing the client's sense of well-being. And, when of necessity objective problem solving is required, it must be grounded in the subjectivity of the specific nurse-client relation.

The implementation of moral education within the nursing education paradigm is necessary to facilitate the development of skilful and compassionate scholar-clinicians able to respond to the needs of individuals in a troubled and changing health care delivery system. Caring, however, is not learned through a specific discussion or the implementation of defined skills. Rather, the caring pedagogical relation between teacher and students fosters the development of a learning community which emphasizes both the cognitive and affective aspects of caring and permits the active and imaginative exploration of ideas.

Chapter III

Research Approach

The purpose of this investigation was to explore the thoughts and feelings of a group of nursing students' perceptions related to learning about caring during a clinical nursing practice experience. A phenomenological perspective was selected to facilitate investigation of the students' contextual reality, and foster the development of a shared meaning about caring, between myself and the students (Hammersley & Atkinson, 1983; Merriam, 1988; Rather, 1992; Watson, 1988).

This chapter is a description of the process engaged by the students and myself to bring-forth the essence of their experience concerning learning about caring during a clinical practice experience.

The Students

I had the opportunity to interview six students for this study. All the students had been members of my clinical practice groups for six to thirteen weeks during the 1994 spring and summer semesters. At the completion of the clinical practice rotation each student in the group received a letter of invitation (Appendix A) explaining the intent and mechanics of the study. Students wishing to participate in the study contacted me and I again reviewed the intent of the work and answered any questions.

I chose to ask students to participate at the end of their clinical practice experience so that during the practice time, we could focus exclusively on the work at hand. During clinical practice students work ardently at the application of newly-learned concepts, attitudes and actions. I have a dual function. I assist students to learn about caring for others through the delivery of nursing care, and I evaluate the safety and competency of their performance. The evaluative component of the process often causes students to feel scrutinized and 'under the microscope'. Not wanting to add, in any way, to the strain that students may already feel in the clinical area, the study was discussed only when the clinical practice experience was complete. Two students from each clinical group volunteered to participate in the project.

Prior to completing the interviews and photocopying students' journals a consent form was signed (Appendix B) indicating that participation was voluntary, and students could withdraw at any time, without jeopardizing their educational process. The consent form also indicated the students agreement to release their journals for photocopying and/or participate in an audio-taped interview. Students were assured that neither their names nor any identifying characteristics would appear in any published or unpublished material. Each student therefore, chose a name to be identified by in this work. Further, students were

advised that the audio-tapes, photo-copied journal entries, transcripts and computer discs pertaining to this study would be destroyed at the completion of this work.

Two of the students, John and Diane, were completing their final thirteen week practicum in a traditional program. The four other students, Keeka, Laurie, Maria, and Rhamba had just completed the first year practicum experience of the baccalaureate program.

John is a 32 year old Caucasian male who holds a Bachelor of Arts Degree in Archeology. He decided that nursing would allow him to care for people more than he could as an archeologist. His practicum experience was on a respiratory medicine unit in a large tertiary care institution.

Diane is a 23 year old Caucasian woman who had been working as a clerk at Overwaitea Foods. Originally from a small interior British Columbia town she often found it difficult to adjust to urban life. Diane completed her final practicum experience on a cardiology unit in a tertiary care institution.

Keeka is a First Nations woman from the Statimix band. She is 37 years old and has worked for many years as an hospital unit clerk. She too finds the city a difficult place to be, and plans to return with her family, to the Cariboo once finished school.

Laurie is a 23 year old Caucasian woman who became interested in nursing while taking an industrial first aid course.

Maria is a 23 year old Filipino woman. She had been in California working as a medical assistant in a physician's office.

Rhamba is a 24 year old Hindu woman who had been working at a bank and taking financial management courses. She felt, however, that she wanted to work more closely with people and after completing some biology courses entered the nursing program.

Keeka and Rhamba completed their first year seven week practicum experience on an acute care medical ward that included a palliative care unit. The experience was based in a community hospital.

Laurie and Maria completed their first year six week practicum experience in a community hospital, on a long term care unit.

Information Collection

Student interviews were audio-taped and lasted approximately an hour. Students selected the time and place of their interview. The opportunity to place the interview in their "own territory" (Hammersley & Atkinson, 1983, p. 125) was an attempt to promote students' comfort with the situation and encourage conversation. The majority of the students preferred the college to other settings.

Interviews were conducted in the nursing education resource centre or faculty offices. One student was interviewed in a small room at a public library and another in a classroom at Simon Fraser University.

Interviews are purposeful conversations directed toward developing a shared understanding of anothers' perspective of the world (Hammersley & Atkinson, 1983; Merriam, 1988; van Manen, 1990). A thematic schedule was developed in lieu of formal interview questions to ensure that the students' thoughts directed the interviews (Hammersley & Atkinson, 1983). Students were asked to identify their most worthwhile nursing experience; to describe a caring and non-caring incident; to define caring; and to discuss how they learned about caring. Usually, it was unnecessary to ask specific questions related to these areas as students raised the points naturally during the course of the conversation. The use of non-directive interview techniques ensured that students' responses guided and structured the sessions, and permitted the students to reflect and disclose their perspectives on learning about caring according to their perceptions (Hammersley & Atkinson, 1983; Merriam, 1988; Marshall & Rossman, 1989).

To substantiate that the interviews accurately portrayed their experience each student received a type-written copy of their transcript for reflection and verification. Students were contacted approximately three

weeks later to determine if they would like to schedule a
second interview. The purpose of the second meeting was to
allow the students to clarify or change any information
(Guba & Lincoln, 1989). Participants all indicated
satisfaction with the transcript as an accurate illustration
of their thoughts.

Information from students' journals was used to
augment interview information. The personal and subjective
information of journals provides "a reliable source of data
concerning a person's attitudes, beliefs, and view of the
world" (Merriam, 1988, p. 112). All students in my clinical
groups are asked to reflect about their nursing practice
experiences in a written journal. In some instances, their
reflection was guided with learning activities related to
caring (Appendix C). Activities were not identical for each
group, but modified according to the professional
maturational level of the students, their level of clinical
expertise, and the educational goals of the semester. The
clinical journals contained a great deal of information
related to the students' clients and the care that had been
delivered. Due to the personal information within the
journals much of the information was inappropriate for
inclusion in this work. Consequently, the material in study
participants' journals was used to clarify my understanding
of information obtained during the interviews.

Analysis

Immediately following each interview I listened to the audio-tape. Occasionally, at this time, I would note general themes but due to the time required for this process it did not occur for all interviews. The interviews were then transcribed. Once this task was completed by the transcriptionist I reviewed the document with the audio-tape and corrected any errors. The corrected transcript was mailed to the student for review and correction. Students were contacted approximately three weeks later to discuss the text. Participants did not make any changes to the documents. Each student thought the transcribed interview presented an accurate representation of our interview, and none indicated a need to add or clarify any information.

Actual analysis of the information began several weeks later by identifying themes. The identification of themes from the information is an attempt not to categorize but to understand the "structures of the experience" (van Manen, 1990, p. 79). Initially, each transcript was read twice. I found it difficult, however, to identify themes in this manner, and so I again listened to the taped interviews. Listening to the students' words grounded me not only in the ambiance of the moment, but also in the phenomenon of caring as perceived by the students. I could hear Rhamba's commitment to another as she sat with a dying woman and I could again see Maria's tears as she talked

about the ways clients reminded her of her grandmother. I could hear the passion and concern in Diane's and John's voices when they witnessed clients being treated inappropriately. And I heard Laurie's and Keeka's eloquent expression of sensitivity and watchfulness for the needs of others. Hearing the students' powerful expression of commitment to others facilitated my reflection on the meaning of their words and experiences.

Using Diane's transcript I reviewed each response and attempted to determine "what the sentence or sentence cluster revealed" (van Manen, 1990, p. 93) about caring. Reflecting on each cluster I attempted to capture the essence of the statement(s) within a word or phrase. The word or phrase became the heading with Diane's words recorded underneath. I reviewed the remaining five interviews and placed like responses and comments under the existing headings and added new headings as needed. Forty-six themes were eventually identified including notions such as communication, watching, how I want to be treated, caring for others, family and relationship with the nurse. The thematic headings used generally originated from the students' words. The themes and the material related to each theme are, however, also the result of my interpretation of the students words. That interpretation has been influenced by the reading I have done about caring as well as personal beliefs. Consequently, the

interpretation of the collected information reflects my understanding of the students' perspectives regarding learning about caring.

I attempted to arrange the themes in a hierarchal fashion by identifying prominent themes and placing other notions underneath. For example, understanding and empathy were listed below communication. This did not prove to be a helpful exercise and was invalidated during the writing of the analysis. Each transcript was read twice from front to back and then once from back to front to ensure that all themes had been identified.

When this process had been completed I again reviewed each transcript and went through a similar process to ensure that similar conclusions would be attained. Though some themes were reduced or simplified, the outcome was essentially the same.

Trustworthiness

The concept of trustworthiness appears to be an accepted evaluative criteria for qualitative work (Guba & Lincoln, 1989; Polkinghorne, 1988; Talbot, 1995). Trustworthiness is established by describing the "free flow of information from the participants...and how it was accomplished" (Polkinghorne, 1988, p. 117). It involves demonstrating a fidelity to the phenomena being considered rather than to a research method (Eisner, 1985b; Hammersley & Atkinson, 1983). Issues of trustworthiness will be

examined here according to the criteria of "credibility,
transferability" (Guba & Lincoln, 1989, p. 236-241) and
"verisimilitude" (Connelly & Clandinin, 1990, p. 7).

Credibility is established by ensuring agreement
between the "constructed realities of respondents and the
reconstructions attributed to them" (Guba & Lincoln, 1989,
p. 237). This has essentially been accomplished by
providing students with copies of their transcripts for
review and correction. Transcripts of the audio-taped
interviews were mailed to the students. Students were
contacted approximately three weeks later to determine if
they wished to clarify or alter any of the transcript. All
the students at the time of the telephone contact indicated
that the transcripts provided an accurate representation of
our conversation. Students have also been provided with
copies of this document as it has progressed. The purpose
has been to allow them to read and reflect on my
interpretation of their words. They have been asked to
contact me if they wish any information changed, or if they
feel that the document does not correctly represent their
thoughts. While students have contacted me to discuss the
document, none have expressed any concerns about how they
are represented nor has anyone requested any changes.

Verisimilitude has been demonstrated by ensuring that
the students and I remained faithful to the exploration of
learning about caring. Within the text this is demonstrated

by using the students' words to portray their perspectives on learning about caring.

Each interview was unique as the student and I created a relation that explored their understanding of learning about caring. Some students, by nature more talkative and reflective, readily shared information in greater depth. This did not, however, influence either the research approach or themes. During the interviews, students candidly expressed personal thoughts and feelings related to caring. Many times it was difficult for students to articulate their thoughts. The struggle to reflect their ideas appears in the transcripts as broken words, phrases and long pauses. This too, however, represents their lived experience of learning about caring. For ease of readers' understanding, however, the students words within the text have been cited in a more literate format.

During the study I also maintained a journal. The entries centre on assumptions related to caring, student learning of caring, antecedent thoughts, and factors that influenced decisions. Information relates primarily to situations and interactions that occurred with students during clinical practice. I also recorded details of the interviews that the audio-tape could not capture.

> She bounced into my office wearing a brightly
> coloured shirt and dark pants. She said she had
> to wear pants because she was going to work after
> English...We used Krista's office. It was warm
> and stuffy in there, so I opened a window. The
> office is cramped because of the space she and

> Louise share, but it felt ok...Rhamba seemed a bit
> inhibited at first talking with her arms crossed
> in front of her. That soon stopped however and she
> assumed a more relaxed posture...We had several
> interruptions, but she kept talking and kept us on
> track...The interview was energetic and
> upbeat...One piece that stood out for me was her
> statement, similar to the other students that
> caring was learned in the family and could not be
> learned or taught in nursing classes...(Pierson,
> journal entry, July 7, 1994)

Information collected from my journal was used to further

augment or clarify perceptions as I wrote the text of this

document.

The intended outcome of this study is a document that

authentically records the contextually based reality of a

group of nursing students. The understanding of learning

about caring that has emerged from this work is a

constructed and shared awareness developed through human

interaction. As a clinical teacher and as an interviewer, I

participated with the students to uncover and understand

their meaning of learning about caring (Hammersley &

Atkinson, 1983; Lather, 1991; Merriam, 1988; van Manen,

1990). There was no attempt to identify and control

conditions or variables. There has also been no attempt on

my part to maintain an objective or neutral attitude.

During these experiences it was not possible to "step

outside...[my] own humanness" (Guba & Lincoln, 1989, p. 67)

and disregard personal experience, expectations, and beliefs

(Eisner, 1985b; Guba & Lincoln, 1989; Hammersley & Atkinson,

1983; Lather, 1991). This exemplifies the reflexive nature

of this type of inquiry. In seeking to uncover the essential meaning of an experience the investigator is the primary instrument of research and part of the experience and phenomena being studied (Guba & Lincoln, 1989; Hammersley & Atkinson, 1983; Lather, 1991). It is the reciprocal nature of the relationship that encourages reflection and a deeper understanding of the meaning of caring for both myself and the students.

The description of learning about caring generated, provided many insights into students' experience and as such adds to the developing base of information (Connelly & Clandinin, 1990; Guba & Lincoln, 1989; LeCompte & Goetz, 1982; Marshall & Rossman, 1989). The applicability of the study findings to other contexts, however, must be judged by the readers. The rich and thick description of the phenomena of learning about caring generated from the collected student information provides readers with the opportunity to make these judgements. Nursing students in comparable programs may identify similar experiences and responses to those experiences which may also facilitate judgements of transferability on the part of readers.

There is no formal proof of trustworthiness. The process of information collection and analysis has been documented. Attempts have been made to ensure that participants had the ability to reflect and comment on information gathered as well as the actual text. It is the

work of the reader to determine the trustworthiness of the information.

Reciprocity

Reciprocity is often discussed in terms of a tangible response to participants for their time and sharing. Marshall and Rossman (1989) suggest that the interviewer may give "time, feedback, coffee, attention, flattery or tutoring" (p. 69) as appropriate gratuities for participation. And certainly, each participant in this study received a gift certificate with their copy of the transcript. I think, however, that these tangible measures may obscure the substantive understanding of reciprocity that entails "a mutual negotiation of meaning and power" (Lather, 1991, p. 57). Genuine reciprocity is the result of the interactive nature of the interviews and the collaborative relationship between investigator and participants.

This chapter is a review of the process of this research study including information about the students, information collection and analysis. The notion of trustworthiness was discussed in terms of credibility, verisimilitude and transferability.

Chapter IV

A Group of Nursing Students' Perspectives

on Learning about Caring during a

Clinical Practice Experience

Nursing students are in the process of learning to care for others. They labour intensely applying new concepts and engaging in new behaviours and attitudes, in various clinical practice settings. During their practice experiences this group of students clearly noted what may be considered a paradox related to learning about caring. First, students were equally influenced by caring and non-caring experiences. That is, it was often the absence of caring that facilitated their understanding and articulation of caring. Second, students described how they learned about caring while suggesting that caring could not be taught.

This chapter presents my understanding of the students' perceptions of learning to care for others during clinical practice experiences. The information is taken from our interviews and augmented with material from their clinical journal entries.

The Paradox of Learning about Caring

The students discussed how they learned to care and all participants were adamant that caring could not be taught. The students perceived caring as an inherent quality and resolutely denied that caring could be taught to an adult.

>...I think you have to have the ability to
>care...I think you either have it or you don't...
>
>We can't make everybody caring. Well you can talk
>to people but sometimes they don't hear...I mean
>you can't make a person care.
>
>...I don't think you can teach people to be caring
>people.
>
>I don't think that you can teach someone to be
>caring, I think it has to come from within.

In the minds of this group of young people caring is a

disposition possessed by an individual (Barrow, 1990). It

is a quality that may be influenced by experience but is

primarily understood through typical family relations.

Viewed as a natural way of being that cannot be taught,

the students did feel however, that they learned about

caring in their family of origin, usually from their

parents.

>...my parents have a lot to do with my being
>caring. They're very caring people, they're
>willing to give anything...
>
>...I think you learn about caring from the people
>that you're surrounded by and that you grow up
>with, your friends and family...

Each student provided detailed descriptions of caring within

a family structure that they believed influenced their

ability to be caring.

In the clinical areas students did not view their

observation of experienced nurses at work, classmates and

their clinical teacher as a way of learning about caring.

They were sensitive, however, to the presence or absence of

caring. It was often the absence of caring that generated the most learning. As wisely stated by Laurie:

> ...if you see always the perfect example of caring, you won't always learn the most you can; sometimes you need to see the other side...you learn a lot because you say boy I won't ever do that to somebody or make them feel that way...

The students witnessed many non-caring incidents. Frequently, conversations with students privately and in group conference centred on their observations and their struggle to understand non-caring interactions.

During some of the interviews students had difficulty trying to articulate thoughts about caring. Several times it was easier to begin with descriptions of non-caring episodes. Diane passionately describes a non-caring situation she witnessed as her way of beginning to delineate the conditions of caring.

> The LPN was dragging this man in a wheelchair, with his bare feet like this on the floor - [demonstrates with heels on the floor and toes pointing up to ceiling]. This client was really weak and had hard time speaking. He wasn't in very good shape and he had a big mess in the bed, a brown code, and the LPN wanted to take him for a bath. Well this man did not want to go for a bath. So the LPN was dragging him, reverse in the hallway, and the client was trying to say something, but the LPN was not really listening to him, and just kept saying, "It's okay, you know, it's okay. You're just going for a bath." The LPN was trying to make it like he cared, and he didn't. Obviously didn't, because he's forcing this man to take this bath...it was just because this man was a heavy load and the nurses were frustrated with him. That was the most uncaring situation I've seen.

Diane was outraged by this situation. Witnessing the client being treated as an object offended her sense of autonomy, justice, and caring. She appropriately intervened in this circumstance by taking over from the practical nurse and assisting the client to regain his dignity and control of the situation. She did so by becoming engaged with the client, establishing a dialogue and ascertaining his wish in the situation. Diane was able to turn this into a caring situation for the client.

Rhamba also observed a non-caring incident.

> ...when the nurse transferred [1]Mr. Devris, she said "I'm not rough, you're just too fragile"...she just kind of plunked him into the wheelchair and Mr. Devris is very fragile...

Rhamba is uncomfortable watching this scene as she is aware of the client's vulnerability and fragile physical and emotional status. She used the notion of "military" to characterize the manner of this nurse.

> ...She's a good nurse but she's very military. I think she's a good nurse technically, but the way she treats people...communication and emotional care are something she needs to work on...

Students frequently noted task-orientated, objectifying behaviour that could be considered efficient, but not caring. John wonders "what the heck are nurses aspiring to when they're just being technical?", and noted that a senior nurse on the unit where he completed his practicum was thought to be "rather endearing" for exhibiting caring

1 All client names have been changed

behaviours such as "spending time with [someone who was uncomfortable] talking to them about the procedure or whatever..."

The students also had many positive experiences with nurses on the units. Generally, the occasion to observe an experienced nurse at work provided them with a good basis for their beginning practice.

..And she was willing to explain everything to me as she went along...

...I think the nurses are the people that are there, they know the way the unit works and by watching the way they do things so you can learn...

I think following other RN's around that gives students confidence in knowing how to approach a client. We learn by watching...

Observation of Registered Nurses in their daily work assists students to acclimate to the atmosphere of the unit and to feel comfortable within the setting. This generally facilitates their learning, interactions and clinical judgements (Jenks, 1993).

Nursing unit staff tend to be regarded as omnipotent and students place a great deal of emphasis on their relationships with unit nurses. They clearly indicated that they felt cared for by some staff and not others;

...they weren't willing to teach us or let us watch. I mean there were some really good nurses on that ward but then there were some that weren't very co-operative.

The students felt most positive about those nurses who were open to explaining their actions and to learning from them.

Maria's positive experience with a nurse in a long-term care agency illustrates this point.

> one nurse would say "well tell me if I'm doing anything that's not the way you were taught because I like to know the new things". She was excellent and I told her some of the things that were different and...she said "okay, that's nice, I'll read about that"...

Recognition and acknowledgement of the student's knowledge and the willingness to be a co-learner promoted a sense of collegiality for the student. Maria described this individual as the "collaborative nurse".

Rhamba had an interesting experience in this area as she explained to a nurse how to correctly perform a procedure. In our dialogue, her discussion of this incident focused around the need to always be open to learning and change even after you've been doing this work for many years.

> ...I said we were taught to flush the butterfly after the medication had been instilled and she didn't say, "that's not right". We went to the manual and she said "okay, you're right and I'll start flushing the butterfly with saline after the medication"...I felt good because I was able to teach her some thing (laughing) not thinking that I'd be able to teach anybody anything especially since I'm a student and the nurses know everything...

Positive modelling by unit nurses also assisted students to understand caring and the delivery of nursing care. Rhamba recounts an experience with one nurse in particular.

> Well the nurse realized that the medication the client was getting wasn't enough for him and he

> was still in a lot of pain. And for someone to be
> in that kind of pain its just not right...
> Everything that she did for him was caring.
> Talking to his family, just talking to him,
> watching him and assessing his intake and output
> and all those kinds of things to come up with a
> conclusion about changing his medication.

The nurse's reaction to the situation demonstrated to the student a meaningful and caring response to an individual's experience of discomfort. I asked Rhamba if being involved in this situation affected the way she provided care to people.

> Yeah, because I got to see how doing our
> assessment isn't just looking at the person; its
> talking to them and watching them...

John also had a positive experience with an expert nurse. He spent an observational day with a clinical nurse specialist for pain management. He was impressed by the expert's ability to focus on the client in a holistic manner, despite the situation.

> The clinical nurse specialist had established
> long-term relationships with these people there
> for chronic pain management. She knew all about
> them....actually I saw her doing therapeutic touch
> with a person that was being discharged and she
> managed to get really focused. Even though there
> was a hubbub on the unit, she could still do
> therapeutic touch and get the client into it too.

The students indicated that they also learned about caring by observing their clinical teachers and each other. Observation of their teachers and peers, however, did not have the same value as did observation of clinical experts. Some of the published literature suggests that clinical teachers play a stronger role in the development of caring

behaviours (Betz, 1985; Nelms et al., 1993) than suggested by the study participants. As well Davis (1993) suggests that as students mature, their judgement of clinicians shifts from a sense of identifying "good and bad characteristics" (p. 633) to a sense of developing relationships with "creative carers and trusted friends" (p. 634). This would not seem to hold true for this group of students. Both junior and senior students identified positive and negative qualities of the staff and formed relationships with those considered caring.

Generally, the students felt that only caring individuals would be attracted to nursing, "...coming into something like this you have to have the desire, the want and already be kind of that way..." and yet the students clearly identified that "...not all nurses care..."

The belief that all nurses must be caring individuals presented another facet of the paradoxical nature of caring. Consequently the students were compelled to try and reconcile their notion of all nurses caring with observations of non-caring behaviour. Sensitive to the ambiance of the acute care settings, students suggested some reasons for nurses non-caring behaviour. It was felt that some people "are not naturally caring", but also that "financial restraints", "the political stuff", and "workload" played major roles. Some students also proposed

that non-caring behaviour may be an evolutionary process due to years of working as a nurse. As stated by John:

> ...Maybe that's what caring is after you've been at it for ten years or something, I don't know. Maybe that's the only way you can do it...Maybe that's just human nature. I'll give it that possibility. So, but I think if you go into the job, you should be able to (pause) maintain the standards that you start with...

Nurses on the unit where Diane was working suggested that she would change in time.

> And they just say...Oh, you're just a student. And you wait till you start working. Things will change....You wait. Pretty soon you're not going to want to do this any more, because you won't have the energy.

Morse et al. (1992) suggests that constant exposure to human suffering may alter nurses' genuine empathetic responses and therefore, the implementation of caring. Nurses are unable to remove themselves from the daily exposure to the experience of others' suffering. Nurses are present with clients during times of psychological, emotional and physical discomfort, pain or fear. The suffering of others is seen and felt. Often, there is personal distress because we are unable to ameliorate a situation. The students all talked about suffering and identified the different ways watching human adversity affected them.

John, a senior student is acutely aware that suffering is an element of nursing, and that the challenge is to

continue to care, and convey caring despite the day-by-day

barrage of human sadness.

> ...you're going to be exposed to people that are
> often at their low and maybe getting lower. And
> you may have to work on a long term care unit with
> a lot of suffering and anguish, and hopefully you
> can mellow it out. But not always. The suffering
> is always there as soon as you even get close to
> the hospital...The caring part is acceptance.
> Somebody may be going down hill in their health,
> and you may have to accept the fact that you
> cannot change them, that you're there to make them
> comfortable, and improve their quality of life...

Maria was also considering some of these ideas when she

expressed her concerns to the head nurse of a nursery where

she participated in an observational experience.

> I asked the Head Nurse, "Do your nurses cry for
> these people". How can you be caring and then not
> cry or not feel sad for somebody...and she said,
> you can cry as long as you still can help the
> family...

Acknowledgement of nurses' feelings has been a contentious

issue. Traditionally, demonstrations of emotion on the part

of nurses were thought to be evidence of over-involvement

and therefore, severely discouraged. More recent thinking,

however, proposes that there is a "delicate balance"

(Uustal, 1992, p. 12) between caring for others and caring

for self. It is suggested that nurturing that balance

sustains the ability to continue caring for others over

time. Laurie expresses this idea aptly.

> I think that a really important part of caring is
> where the nurse is at themselves because if you're
> not taking care of yourself its hard to take care
> of other people...its really important that the
> kind of care you give other people is the kind of
> care you're giving yourself.

Caring is "both self-serving and other-serving" (Noddings, 1984, p. 99). The intent in a caring relation is not to diminish the one-caring, but rather to augment both members of the connection. The non-caring incidents that students observed generated a tension for them that was not easily resolvable. They correctly assert that the present health care delivery system perpetuates and sustains many of the observed practices. Most of the students suggested that for themselves however, the mutuality of the caring relation was nurturing and one way of maintaining themselves as caring individuals. As Diane states:

> ...when you really help someone, you see it in
> their face, in their eyes, and you feel it inside.
> It'll just be a little feeling of joy, or a
> feeling of self-worth, like I did a good thing for
> that person. And I think that's what caring is
> all about...

Initially, John was unsure if he received any sense of caring from his clients. Following some reflection he stated:

> They don't have to show that they care, for you to
> be caring. However, you usually end up with
> clients showing that they feel good about you
> being there. So, that sort of confirms that you're
> on the right track.

Maria drew a sense of being nurtured from her client's recognition of her.

> ...she didn't remember my name though, but she
> remembered me and that made feel good too.

Rhamba expresses a similar sentiment.

> ...I was gratified by seeing these people and just
> the little bit that I could do for them

> that made it even better...it's rewarding and
> there are a lot of downfalls too but you know,
> there is always going to be...

In discussing downfalls, Rhamba, acknowledged the sense of sadness experienced when clients' physical conditions are deteriorating, as well as the stress and strain present in the day-to-day world of human relations. Each student experienced feeling upset due to clients' actions. Their commitment to caring, however, sustained them in the relation. John recounts his practicum experience with this issue.

> ...I've run into two circumstances this semester
> where somebody was really nasty and then...I
> discovered that just like the textbook says,
> they're nasty for a reason. All you need to do is
> find the reason... '

Keeka had encountered a difficult situation with a client behaving inappropriately. Our discussion about this incident indicated that she aptly set limits and managed the episode with grace and dignity. Her statements regarding this incident clearly articulate her feelings as well as illustrating the commitment to the relation.

> ...I'm just balancing myself and the client too so
> that no one's feelings get hurt..."

Balance is a critical notion to the ethic of caring. The willingness to receive and engage in the concern of an other, as well as to receive care from the other, generates a dynamic balance or rhythm. Balance is created by the cyclical 'to and fro' of caring between individuals in the relation. The students are intuitively aware of this rhythm

and respond genuinely to their clients; and sometimes that response entails withdrawing from the situation. It is this conception of balance that Noddings (1984) refers to as the "toughness of caring" (p. 98). It is necessary to honour and acknowledge the thoughts, feelings, actions, and wants of the one-caring as well the cared-for in order for authentic caring to occur.

Students learned about caring during their clinical practice experience by observing others, particularly practicing clinicians. They seemed adept at identifying and choosing appropriate behaviours to emulate. As suggested by Rhamba, she learned about who she wanted to be as a nurse by observing others.

> I know what kind of nurse I want to be...because I've seen all the different or some different kinds of nurses. I don't want to ever be cold and military. I want to be compassionate and willing to try new things and help others.

The time students spent with nurses working on the units provided them opportunities to learn about caring and about the delivery of nursing care. The caring relation between expert nurses and clients tends to be actualized through a sense of "knowing" clients (Tanner, et al., 1993). Following their clinical practice experiences students also spoke of the importance of knowing clients and they described what that meant for them.

Learning to "Know" Clients

Clinical actions and decisions are based on the accumulated information obtained from clients as well as a variety of other human and scientific factors such as context, culture, illness, disease process, and time. Expert nurses attend to these factors and client situations holistically, while students functioning at the level of novice and advanced beginner, tend to be disconnected and often unaware of all factors in a situation (Benner, 1984; Benner, Tanner, Chesla, 1992; Benner & Wrubel, 1989). Consequently, students are frequently perceived to rely on abstract principles and propositional knowledge to guide interactions, decision making, and instrumental actions (Benner, 1984). The notion of recognition as expressed by the participants, however, involves more than identifying and labelling a symptom or a situation according to external principles. It also encompasses a sentient perception of the individual. The results of this investigation would suggest, however, that students may have a greater understanding of clients' situations than supposed.

The recognition of clients' needs was viewed by all the participants as the most important determinant of caring. As Diane states:

> I think that he [another student] was a very
> caring person...he always made sure he knew what
> was going on with the clients. He'd recognize what
> was happening with his clients...

Or as expressed by Laurie:

> If you are able to listen and watch your clients,
> and understand what they're saying, then you
> should be able to make their stay better...

An example of recognizing client needs is provided by

Laurie as she relates her experience during the second term

clinical practice experience.

> ...in the beginning, our conversations would
> quickly turn to tears and I think part of that was
> because of the M.S. - so there was the disease
> side of things...once I started to learn how to
> guide our conversations so it wasn't tears within
> two sentences of when we started talking, then we
> could get into a lot more and talk about what was
> going to happen with her in the future, about
> death and dying, how she felt about her religious
> beliefs, how those beliefs had changed over time,
> how she felt with her family not being there, with
> her husband not being there anymore for her...in
> the beginning, I wasn't really sure how to react,
> so when she'd be upset I'd try and console her but
> that really wasn't helping, that wasn't what she
> was needing. I think she was beyond the point
> where she needed a hug...I think that she knew
> what was happening to her, that it wasn't going to
> change, or get better for her...She needed to get
> some words out and get past the tears. So
> sometimes I would talk over her so that we could
> change the conversation and then she would stop
> crying and think about the conversation...

Initially, Laurie found conversations with this client

"frustrating", in part because she was unsure of how to deal

with the client's emotions. She did, however, perceive that

the client was in need of more than sympathy and began to

try and direct the conversations. I asked how she knew or

learned to guide the conversation away from the tears.

Laurie thought she had learned "some of it in class, but I

think its more than that, I think its from talking with

other people, just through life experiences and knowing some of my needs...and watching her and seeing, and trying different things with her". Laurie listened attentively and compassionately. Her responses were directed not only by communication principles and an initial understanding of chronic illness and loss, but also by a sensitive perception of this woman as an individual. As she wrote in her journal:

> ...I'm trying to understand the things that make her 'superficially' upset (perhaps) as a result of the M.S. and the things that make her truly emotionally upset. As I am getting to know her I'm finding these areas out more and more.

Laurie is beginning to develop a sense of the client that transcends a superficial identification of needs based on objective knowledge. She is beginning to "get a grasp of the client, get situated, understand the client's situation in context with salience, nuances and qualitative distinctions" (Tanner et al., 1993, p. 275). Further evidence of this beginning to 'know' is apparent in another of Laurie's journal entries. During her second last clinical week she noticed a change in the client's reactions and condition which led the two of them to a discussion regarding the client's downward disease trajectory.

> Over the weeks that I've been there [the client] has been fairly constant, but this week she seemed to have changed...as we began to talk she appeared to be quite agitated (more than usual)...she had spilled a bit from her drinks [at breakfast] - we talked about it and she said that she's starting to have a bit more of a hard time with her hands and when she was turning herself from side to side

> while she was getting dressed she said she
> 'doesn't know what [she'll] do when [she] loses
> control of [her] arms'.

Together, the client and Laurie established a profound caring connection. Motivated by a desire to foster the well-being of the client, Laurie's example illustrates recognition of needs as well as an active sense of engagement, genuine responsiveness and presence (Benner & Wrubel, 1989; Carper, 1978; Morse, Bottorff, Anderson, O'Brien & Solberg, 1992; Noddings, 1984; Roach, 1992). Laurie, as one-caring directed energy toward understanding the experience of the client and promoting the client's comfort and autonomy. In concrete terms this was accomplished by initially recognizing the needs of the client.

The students also identified the idea of watching as a significant process naturally extending from the notion of need recognition. In our conversations students would casually mention 'watching' as a part of their experience of caring for clients. As noted previously in Laurie's comments "If you are able to listen to your clients, watch your clients, or ...and watching her and seeing", the notion of watching flows quite naturally within the conversation. When asked to explain further what was meant by 'watching', students often had difficulty finding the words. Consequently, watching was most often expressed in terms of lived experience with clients.

John, in his journal wrote, caring motivates consistent monitoring and thorough assessments. I asked him to further explain his meaning of consistent monitoring.

> ...the idea about encourages monitoring was just the fact that I wouldn't want to sit at the nursing station reading a magazine and neglect going on a hourly check. As a matter of fact it might be difficult for me to stick to one hour because I want to go, make sure everybody's doing okay. And I prefer to spend time in the rooms, talking to people...

Throughout John's journal he talks about checking on clients to note their physical and psychosocial condition. He connects a sense of feeling complete with knowing how his clients are physically and emotionally.

Rhamba identifies watching as a way of knowing the client's needs that stimulates action.

> ...our assessment isn't just looking at the person its talking to them and watching them. With Mrs. MacGregor, for example, I couldn't really do much for her except watch her and if she was uncomfortable change her position or if her mouth was dry and her nares were dry to apply some muko jelly...

Maria also describes her sense of watching over someone.

> ...I gave him his medications and I talked to him and he could feed himself and stuff like that so it wasn't too much but he still needed some care, and then I just watched over him...

When asked to clarify her notion of watching over someone she described watching in terms of physical care.

> ...if his lips started turning blue then he needed more oxygen so that's what I had to watch him mostly...

Yet, when asked what made this a caring situation for her she replied "...like I watched over him..."

The idea of watching may be conceived of as a visual skill with a resultant sense of detached observation. Etymologically, however, the word is derived from notions of "attending, guarding, preserving, and vigilance" (OED, 1989). The idea of vigilant regard or attention perhaps better signifies the students' notion of watching.

Students at the level of novice and advanced beginner approach client situations with fewer substantive patterns and less concrete nursing experience. Consequently, students do rely on external authorities for certain elements of practical knowledge. Students are, however, quickly accumulating experiential knowledge that will in time, develop into patterns of understanding. They are also developing an intuitive sense of the client by using strategies such as sentient perception and vigilant attention. The students notions of need recognition and watching may be their initial steps toward the expert's sense of knowing clients.

The students approach to clients is guided by an authentic caring sentiment that encourages active participation and sensitive, empathetic responses (Morse et al., 1992). The establishment of caring relationships and need identification was accomplished using a variety of strategies. Effective communication was considered a

critical and necessary skill for developing client relationships. Laurie provides a synopsis of the sentiment expressed by the students.

> ...in term one we were doing all this communicating, and it just felt like well why are we doing this, I want to be able to give the injections and do all this kind of stuff but I think communication is, is one of the biggest things in nursing because you have to understand what the client wants...

Understanding what the client wants is one communication strategy used by the students to gain knowledge about clients. It is a connected way of knowing that focuses the student on both receiving and responding to an other (Belenky et al., 1986; Gilligan, 1982; Noddings, 1984; Whitbeck, 1983). Within the concept of understanding lies the idea of acceptance. Concretely, acceptance was actualized by being non-judgemental. Laurie illustrates the notion of acceptance from one of her experiences.

> ..."And he's an alcoholic, a street person really difficult, you're going to have your hands full". That was what I got at the first report and I thought oh great, here I go, but after awhile it was like so what, am I going to treat a prostitute that comes in like garbage, no, because she's a person.

Laurie's willingness to accept her client as an individual portrays an attitude of receptivity. She is willing to be engaged and responsive to him as a person. She explained her sense of willingness to be with him as trying to find the genuine person:

> ...I think it comes from trying to see through to another person and saying like he's not, he's not

a bastard and he's not an ornery old bugger, he's
difficult but let's find the nice side of him
because I don't want to know the awful side of
him..."

Laurie's statement that she did not want "to know the awful

side of him..." is not to suggest that knowing the negative

side of an individual is to be avoided. Rather, it was her

attempt to identify that knowing the client at a deeper

level - at the level behind his cantankerousness would

facilitate her understanding of his behaviour and

consequently their caring relation. Her caring relationship

with this gentleman led to him, for a short time,

participating more fully in his care. He was, however,

transferred from the unit.

Keeka and John expressed similar sentiments

demonstrating acceptance for their clients in a

corresponding manner.

> The most worthwhile learning is that these clients
> are human beings and not just a disease. Some
> people will say, "the ectopic pregnancy down the
> hall" whereas you can call individuals by a
> name....I shut my ears to a lot of things that are
> being said in other places [like the nursing
> station], and I go in to client rooms open minded
> and have the client explain to me how they're
> feeling rather than someone else explain it from a
> different point of view, I respect the client's
> view because they're feeling that way...
>
> ...love is accepting somebody and...Just loving
> the individual for the fact that they're a human
> being. That's why I'm not one of those people
> that could refuse to care for anybody. Seriously,
> I mean, I, wouldn't even be able to refuse
> Clifford Olsen.

Acceptance may be considered part of the human "preparedness to care" (Noddings, 1984, p. 86) and, as such, a constitutive element of the caring relationship. In the students' conception of caring, acceptance and understanding were prominent factors.

The ideas of understanding and acceptance are necessary for reliable identification of client needs. The outcome of need recognition is a response. The primary and most powerful response identified by the students was that of being-with or presence. The notion of presence adds another dimension of depth to the caring relationship. Maria characterizes presence as being there for clients.

> But then there's caring as in you're feeling responsible for the client's care. I guess if you're caring just for the job, just to get the money, just to get the day over with... you're making sure everything is done. I think that's one kind of caring. Then the other caring is to have a little part of yourself with the client like, you really want to be there, you want to talk to them, you want to see them get better...

Even now I am able to hear Maria's passionate commitment to be with another as part of caring. This notion formed an essential component of her definition of caring.

Rhamba depicts the idea of presence in her recollection of caring for a dying woman.

> She really got to me because she was such a sweet lady and at first she didn't want anybody fussing with her at all and closer to the end there she just, there was nothing you could do for her, she just lay in bed and I was supposed to take her vitals and see how she was doing. She looked like she was drifting and so I went and got one of the other nurses to come back and see if there was

anything that we could do for her and there wasn't
really anything that we could do because she was
getting her morphine and she wasn't able to
communicate so it was really hard. I mean the only
thing that I could do was sit with her and just
hold her hand and position her properly so she was
comfortable and that's what I did...

Rhamba notes a physical change in the client's condition and
recognizing that she does not have the knowledge to make a
decision, appropriately seeks the assistance of an
experienced nurse. The expert assesses the situation as
stable and withdraws. Rhamba, however, remains with the
client sitting "with her until she fell asleep". Rhamba in
this instance chose to be engaged with the client, to affirm
rather than abandon her (Benner, 1991; Noddings, 1984).
Rhamba's intuitive understanding of this woman's needs
replaces the separate distinctions of "I and you" with a
shared human experience (Naess, 1968, p. 201). The caring
experience initiated by Rhamba did not involve sophisticated
technology or interpersonal techniques. Rather she
responded in a genuine and empathetic manner to the client
using herself as the instrument of compassion. She held
this client's hand and stayed with her until she fell
asleep. There is a sense of the ordinary about the action
though the feeling is profound. It was a statement of
selfless giving. Taylor (1992) suggested that "ordinariness
is the sense of shared humanity between nurses and clients"
(p. 33) and asserted that the resultant experience engenders
a blurring of the traditional helper/helped role. In this

instance, I do not know if Rhamba experienced a sense of being cared for, but I do know that in talking with her and in listening again to the audiotape, her ordinary action was generated by a potent sense of commitment to care. In the everyday world of student nurses and nurses perhaps it is in the ordinariness of our being that the caring ethos is enacted.

Keeka describes another situation where presence with a client and the completion of ordinary tasks led to an extraordinary moment.

> ...I did have one client who was totally dependent
> for everything; feeding, elimination, cleaning,
> hygiene. She wasn't able to talk and one day when
> I said that I would be back next week to see her
> again she spoke, she said 'okay' and she smiled...

Keeka cared for a dependent and vulnerable woman in a manner that respected the client's personhood. When Keeka had to bring this relationship to closure there was sadness for both individuals.

Recognition of needs including a sentient perception of the individual and vigilant attention to their needs, acceptance, and understanding, serve students as ways to know their clients. Being-with their clients, present with them in the moment, is one manner in which caring is realized.

Saying Good-bye

All nursing students must learn to say goodbye. It is perhaps one of a nurses' most difficult tasks. Goodbyes are

usually tinged with sadness. While glad to see an individual discharged, we often feel the loss of a friend. And death is a good-bye that is always accompanied by a sense of loss.

Keeka spoke of saying goodbye to a client. Not someone who died, but a relationship brought to closure as she (Keeka) would not be returning to the agency. The client had enjoyed Keeka and her company and was angry when Keeka said she would not be returning. For Keeka it was a difficult moment.

> ...when I was saying goodbye to her and telling her that I wouldn't be coming back...she wouldn't talk to me, she looked away and that bothered me because I didn't know what to do. I cared for this person...

I asked Keeka how she felt when the client looked away.

> I said is this what nursing is all about. I asked myself and I thought I have to be able to say goodbye to clients, and I don't know how I'm going to...

Laurie expressed a similar sense of sadness when she came to clinical and found that her client had been discharged.

> ...the one thing I find difficult in some ways is just seeing people for little bits of their life and then not knowing what ends up happening with them. I'm always kind of wondering. I think especially in the beginning because this work is so new and you're so involved with people's lives. You read about their disease and you talk about them a lot...and then you don't know what the outcome is...You wonder and they always sit in the back of your mind and you wonder...I wonder where they went or I wonder how things worked out...

The caring connection can be severed quickly in the practice
of nursing. I explained to Laurie that, for me, there are
still people that I think and wonder about; its like having
the last page of the novel missing. Nurses have many
memories, hold many secrets, and many unfinished books.

The experience of saying goodbye for Diane was
difficult. A few months before beginning her practicum
experience her father passed away due to a cardiovascular
event. I was concerned about her being on a cardiology
unit, though this was her request. We discussed her
placement and she felt she needed to be on this unit.
During the practicum Diane had two experiences involving
caring for dying clients. The first incident involved a
woman who she had not cared for previously. This situation
is not an unusual in nursing, but it is difficult,
especially for a neophyte.

I asked how she felt caring for someone who was dying.

> ...I felt really strange, because I thought - I
> wasn't prepared for it. I wasn't prepared to care
> for someone that was passing away...I didn't
> really know what to do and I didn't want this to
> happen to me...I just totally separated myself
> from the situation. And then it just kind of
> happened. And I was like, okay, you know, that
> was it.

Diane felt no connection with the woman she was caring for
and "separated" herself from the situation. Following this
experience Diane's confidence increased. For her, the
experience had been a rite of passage. The second
experience involved a client with whom she was connected.

> Seeing her so sick, and with tears coming out of
> her eyes. She wasn't really able to speak or
> communicate with me. That was heartbreaking, and
> hard. And I just thought, why are we doing this
> to her - the surgery and all the treatments. I
> don't think she really wanted to live like that.
> I mean, I know she didn't. I don't know why. I
> just know...But you could just see the tears come
> into her eyes, and she would just hold your hand
> with such strength. It was just really sad. And
> then, she passed away...

The recounting of this experience is filled with the words and feelings of connection. The two passages demonstrate Diane's growing maturity as a nurse and an individual.

Diane stated that she had always been afraid of "other people's deaths" and felt that caring for individuals who are dying was an important experience for her.

> It was a big relief, because I had always wanted
> to have someone to pass away while I was in
> school. It was just one of those things that had
> to happen to me now...

Rhamba completed her first year practicum on a combined medical/palliative care unit. She had found the experience worthwhile as "it just made me see how valuable life is..." We talked about her impressions of caring for people who were dying. Rhamba knew that working in palliative care she "wasn't going to be able to see them get any better and see them walk out of there but I knew that I would be able to make their stay more comfortable..." Still, it was difficult to say goodbye. Rhamba had many experiences where she cared for dying clients with empathy and compassion. She worked very hard to help individuals feel comfortable.

For Rhamba as well, caring for dying clients was a rite of passage, a measure of whether she could be a nurse.

> ...I thought if I'd be able to face those kind of cases now that it would really determine whether I wanted to go into nursing. I know if I could deal with dying and death now I can still deal with it maybe five years from now. But if I haven't dealt with dying and death and I've already finished my schooling and I realize I can't deal with people dying, what am I going to do...

Maria, because of her previous work had experienced the feelings of sadness that often come when a client dies. She also talked about the importance of knowing that you could care for someone who was dying as being a measure of whether you could be a nurse.

The students focus on death is interesting, especially the view of caring for the dying as a measurement of themselves as a nurse.

Time to Care

If often feels that "time is of the essence" in nursing; a client in pain, someone stops breathing, a medication due. Each of these situations requires immediate action in order to ensure that discomfort is alleviated, that life continues, or that healing proceed. Each situation, common in the everyday existence of nurses, is influenced by objective time. There exists, for nurses caring within the realm of sophisticated technological care centres, a conflict between harsh, unrelenting mechanical time and receptive, relaxed body time (Lightman, 1993, p. 23). Mechanical time is 0700 shift report and morning

care completed by 1000; it is objective time that is unyielding and without feeling. Body time or subjective time, however, acknowledges and honours natural rhythms. It is the time spent covering for another nurse who is late because day-care must be arranged for an ill child, and it is disregarding the usual routine so that the client who had a restless night, may sleep in the morning. Early in their careers students become aware of the tension between objective and subjective time. Diane notes that even when talking to clients in order to complete an assessment it becomes a technical task bounded by objective time.

> ...in semester six, when I had more time, I was able to organize myself more and I had more time and effort to give to caring...it's really important, I think, to be able to sit down and, and chat with your clients and recognize what their needs are...We do that but only in the skill-oriented way...

This young woman is already cognizant of the tension between the time needed for the active involvement of caring, and the time required for the completion of technical tasks. This tension or sense of "desperation that may occur when the two times meet" (Lightman, 1993, 27) often creates for nurses and certainly, in one instance for Diane, a ethical problem. For the sake of time and efficiency she restrained a client.

> ...Well I think its all got to do with our client. I mean, if I only had four clients, she wouldn't be restrained. You know, I haven't always the time to go and sit with them or watch them.

In my dialogue with students during interviews for this
study, all the participants commented on objective time,
most frequently when describing non-caring. The
consequences of the technological perspective was often
witnessed by students in situations they felt to be non-
caring and typically objective time was the stimulus.
Laurie discusses this point as she describes a situation in
which she and another student were taking vital signs.

> ...when we were on the cardiac ward a client who
> was in his last hours of life was there with his
> family and everyone knew he was dying. We knew he
> was dying and we didn't want to go and disrupt
> that family bonding by taking vital signs. We
> asked the nursing staff if it was really necessary
> to take the client's vital signs. The nurses said
> he's on the list so it has to be done. And I
> thought wait a second, that's not right. I don't
> believe in that and I don't think the nurses were
> right. It caused the family stress by having us
> come in, they didn't want us. We did the vital
> signs as quickly as we could and then left but it
> was a lot of unnecessary distress for the
> family...

Laurie's assessment of the situation was correct. The
gentleman and his family, who were spending their last
moments of temporal time together, were being interrupted
for the completion of a meaningless procedure. The student
recognized the authentic time and understood the depth of
the family interaction, yet unit staff responded only to
objective time, objectifying the client and his family by
insisting the procedure be completed.

Time is essential to the notion of caring. Caring, the
active engagement with another involves a sharing of

experiences in time. The unyielding and felt presence of objective time may affect the quality of care. Students detected the effects of both types of time on their personal practice as well as the practice of others. The thrust to complete instrumental skills quickly and efficiently is the outcome of homage to objective time. The transactional process of caring, however, requires deliberate and active involvement with the client. Keeka describes a situation where trust and caring developed between herself and a client because she was willing to spend time.

> ...I think it was because I spent time with her to do all these things for her and to talk to her and to take her out of the building for awhile, out of her room and out of the little lounge that she used to go to everyday. I think it made a difference to her.

As Diane notes however, often the desire to care is circumvented by objective time.

> ...it's hard when you want to care and can't. I mean, I've been so busy that you want to go into a room and say hi and you can't because you haven't had time. I've tried to make it up the next day, even though they're not my client, I'll just stop in and say, 'Hi, how are you; sorry I didn't come and see you' or something. I will do that. Just so they know that I do care...

As Diane intimates it is objective time and the need to have 'things' done on time, which generally interferes with the manifestation of caring. It is of interest that an hospital, a supposed place of healing, does not honour body time. As Keeka so aptly states:

> ...people don't have the time to care for people anymore...I felt like I had to learn how to put

> clients on a treadmill where you take care of it,
> they go home, the next one comes, that one goes
> home and its on and on and on

It would seem the question to be asked concerns the appropriateness of hospitals as a place of healing if the experience of each type of time cannot be integrated.

There is a paradoxical nature to caring in that it is often easier to describe what is not caring. Clearly, this difficulty arose for the students. The students were, however, also confronted with other aspects of the paradox of caring. This came in their notion that caring could not be taught. Yet, they identified they learned about caring, primarily through the observation of others. Also, they needed to reconcile the notion that only caring individuals would be nurses, even though they identified many non-caring behaviours. This struggle was perhaps the most difficult for it involved an acceptance of the reality of the workplace and clear recognition of the need for change.

This chapter is an analysis of the information obtained during the student interviews and from their clinical journals.

Chapter V

Summary and Some Implications for Nursing Education

<u>Summary</u>

The result of a qualitative process of inquiry, this written work is an account of six nursing students' perspectives on learning about caring during a practice experience in a clinical area. Their words express the complexity, struggle, and uncertainty that characterizes the moral nature of caring and learning about caring (Cooper, 1991).

Study participants had all been students in my clinical groups during the 1994 spring and summer semesters. Two students from each group participated. Four students were in the first year of the baccalaureate curriculum and two were senior students in the diploma program. Students received an invitation to participate in the study on completion of their clinical practice experience. Each participant completed a face-to-face interactive interview directed by a thematic schedule. Interviews were thematically analyzed and forty-six themes identified. In addition, students' clinical journals were photocopied and the information used to augment interview material.

Analysis of the collected information indicated that students were confronted with the paradoxical nature of caring. For the students, the paradox revolved around notions that it is often easier to explicitly identify non-

caring; that caring may be learned, but not taught; and that all nurses, by nature, must be caring people.

The students adamantly stated that caring was a natural attribute that could not be taught. Yet they identified that they learned about caring by observing the behaviours and actions of others. The students' view is congruent with the published literature which suggests that caring is not content that may be discussed in a concrete manner (Benner, 1994; Tanner, 1991) and that modelling is one of the most powerful methods for teaching/learning about caring (Betz, 1985; Davis, 1993; Nelms et al., 1993; Noddings, 1984). Vygotsky (1962) suggests that thinking develops from the "social to the individual" (p. 20) and observing expert clinicians at work provides students with opportunities to incorporate knowledge from external sources into internal patterns of knowing. The nature of the clinical experience provides students with opportunities to observe nurses in all aspects of their daily enterprise. The clinical learning experience also provides students with the opportunity to integrate information and experience related to their observations of caring and the delivery of nursing care into their sense of a professional caring individual. In the Bakhtinian sense, the students are in the process of "authoring" (Holquist, 1990, p. 27) themselves as professional caregivers.

During clinical practice experiences students clearly
identified caring and non-caring behaviours on the part of
working nurses. There was difficulty reconciling their
notions of caring as a natural quality possessed by all
nurses with some of their observations of non-caring
behaviour. They aptly identified that many current social
and political structures generate an environment adverse to
caring behaviours. Some of the participants also sincerely
questioned whether the constant exposure to suffering was
part of the cause of the technical, unthinking, and non-
caring environment often observed. And they wondered what
they would be like as nurses, as time progressed. At this
point, however, their commitment to caring relations with
others was strong and it was difficult for them to imagine
themselves behaving in a non-caring manner. Observing non-
caring behaviours on the part of the nurses assisted
students to define themselves as caring beings and to
solidify personal convictions related to caring for others.
Maria, for instance, in her practice tries to always
consider how she would want care delivered to a member of
her family. Accordingly, she tries to treat clients with
the same respect and care she would give to a family member.

Authorship of self also required the students to define
caring for themselves. In our conversations a connected
relation with clients was viewed as the primary means of
establishing a caring relation. Within that relation

recognition of client needs was viewed as the most important determinant of caring. Recognition was not, however, a simple identification and classification of need. Students' notion of recognition occurred at a deeper level of awareness and involved a sentient perception and vigilant attention to clients and their needs. This sense of attunement with clients resonates with expert nurses' sense of knowing clients. Consequently, the students' notion of recognition may be their initial step toward the expert's sense of knowing.

The difficulty of saying good-bye also arose as a theme. Bringing relationships with clients to closure is often difficult and students clearly identified that ending a caring relationship may be uncomfortable. Students also discussed caring for dying clients and the importance of being-with these clients. Of interest, is that students used care of the dying as a measure of their ability to be a nurse.

Time was another identified significant issue. Even at this early point in their careers students felt the difference between objective and subjective time. The need to complete tasks within a certain time frame clearly opposed the time required for the establishment of caring relations. Caring requires the one-caring to be fully present with the cared-for and objective time often interfered with this requirement.

The similarity between the thoughts of senior and junior students involved in different programs is interesting. Published literature would suggest that there is a difference in the maturity of thought about caring between senior and junior students due to experience. Students' comments would not convey that impression. It may suggest that students come into the program with well defined thoughts about caring; it may also be an effect of the caring-based collaborative curriculum. Pressures in the traditional content driven curriculum did not leave time for discussions of caring or peoples' experience with a health challenge. Students in the collaborative curriculum, however, consider caring from their initial day in the program. Caring is discussed as a concept and the notion permeates the curriculum. Learning activities focus on developing self-awareness and thinking of clients and their care in a manner that supports personhood. The question arises then, can the similarity between these two groups of students, be attributed to the students' work around the concept of caring.

Students clearly described the programs in different terms. Students in the diploma program referred to the curriculum as "task-orientated" and commented that to improve the program more time needed to spent on interactions.

> Right from semester two, where we're learning how
> to do bed baths and change simple dressings, and

    give our medications on time, and chart on time,
    we don't have time to sit down and just chat with
    our clients...

Students in the collaborative program noted that the

caring aspect was "enhanced" and the focus was "to think on

our own" and "work as a team".

The literature reviewed for this study focused on

information related to caring and the teaching/learning

process. The central component of caring was determined to

be connectedness and the constituent elements of caring

relations included an active sense of engagement, genuine

responsiveness, presence, reciprocity and the commitment to

foster the well being of an other (Benner & Wrubel, 1989;

Carper, 1978; Morse, et al., 1992; Noddings, 1984; Roach,

1992). Drawing on this notion of caring, the interactions

that occur between and among students and teacher are deemed

to be the foundation of the learning environment within the

collaborative curriculum. A caring pedagogical relation

between teacher and students is viewed as central to the

teaching/learning about caring. The importance of this

relation and its effect on students can be drawn from

experiences with students participating in this study.

A few months prior to the start of her final practicum

experience Diane's father died as a result of a

cardiovascular event. She subsequently requested to

complete the practicum experience on an acute cardiology

unit. The initial week on the unit proved to be stressful

and demanding, and I was concerned that Diane was having difficulty managing the setting and type of client because of her recent loss. Towards the end of that first week, we sat in the unit's conference room and talked about her feelings related to cardiology, the unit and her father. It was tearful meeting as Diane admitted her sense of pain and grief at not being with her father when he died. She distinctly felt, however, that she needed to be on this unit as part of her healing. During our conversation for this study she commented on this incident.

> And you took the time to listen, and to care, beyond an instructor. You recognized...that here was a potential problem...and then you explored it...You taught me to recognize my emotions so that I can deal with them, because when I get to the real world, I have to do that. I have to learn how to do that on my own. And you taught me how to do that...

During the practicum Diane came to terms with many personal issues. She has since graduated from the program and now works on a cardiology unit in a community hospital.

I do not consider my listening to her as "beyond" the duty of a teacher. Listening and talking with this young woman about her feelings and suggesting ways of managing grief are simply part of a caring pedagogical relationship. Being sensitive to the vulnerabilities of students is a conscious element of knowing students and a necessary component for implementing a caring pedagogical relationship.

Another situation occurred with Laurie, during her first year practicum experience. She was taking vital signs on a cardiology unit and was asked by the unit staff to take the vital signs of a gentleman who was dying. She was distressed by this request and though she completed the task, she later stated to me that she felt this was an inappropriate activity for a student. We discussed all aspects of this incident in depth; why vital signs on this individual might have been necessary, though I believe she was quite correct in her estimation that the signs would not provide useful information; and why she felt it was inappropriate for a student to be doing vital signs on a dying individual. As we worked our way through the layers of thoughts and feelings, Laurie realized that her concerns were related to her own thoughts about death and dying. She later wrote in her journal:

> I really am glad that we were able to have that
> conversation about the necessity of taking a
> patient's vitals when we know they are in their
> last few hours. I had not realized how many
> levels I was concerned/thinking about until I was
> able to verbalize my thoughts.

It is the relation between teacher and student that assisted the student to bring meaning and understanding to a situation. The establishment of a caring pedagogical relation fosters the creation of an inquiring learning environment where students feel safe to share and examine thoughts and feelings that will permit them to grow as caring individuals.

Implications for Nursing Education

The description of learning about caring generated by conversations with this group of students provided some valuable insights into their perspectives on learning about caring. There are some points of interest that require further thought or investigation.

When students were contacted approximately three weeks after the receipt of their transcript they were asked if they had learned anything through their participation in the interview. Several replied they had not realized "how much" they knew until they read the transcript. Consequently, there may be a need for a formal means of closure within each term where students have an opportunity to reflect with their clinical teacher on their experience. The opportunity to perceive and examine their sense of self as a professional caregiver may be facilitated through the articulation of thoughts, ideas and experiences with their teacher. While some would suggest that this occurs during the time of final evaluation I would suggest that this reflective process needs to occur separate from that evaluation. The reflection that I am suggesting here, is not related to their clinical performance, rather it is related to their development as a caring being.

The pedagogical relation between students was not explored within the bounds of this study. Students did indicate that they learned from one another, though not to

the same degree suggested by other research (Beck, 1992a; Nelms et al., 1993). Some students indicated that they watched each other "struggle" to learn about caring, especially in the beginning semesters. They also indicated that they "pulled each other through" the stress of classes, clinical practice, and assignments. This notion of learning about caring from one another, however, was not probed. Exploration of the notion of students' learning about caring through their relations with each other would provide added insight into the teaching/learning process about caring.

At the time of the interviews I did not realize the significance students attributed to caring for dying individuals. This is also an area requiring further investigation. Studies need to be completed which examine the meaning of death and dying for nursing students.

Nursing is not a profession exercised in isolation. At all times a community is involved. Nurse, client and family, involved with other health care professionals as well as the myriad of other individuals working in health care settings, constitute the healing community. Nursing students are being educated to be participatory members in this community. Consequently, there first needs to be a learning community able to provide the support and model for students to discover how to enter caring communities as caring professionals.

The foundation of the learning community is a caring pedagogical relation between teacher and students. This is not necessarily an equalitarian relation, but rather one of total engagement between teacher and student for the time of the interaction (Noddings, 1984). The relation between teacher and students serves as a base for developing an environment that permits active exploration of ideas in an imaginative manner. Working with students as co-learner/expert learner the teacher assists students to develop learning tools and skills that will promote dialogue about client and health care delivery issues, as well as foster a spirit of inquiry.

The results of this study, congruent with the nursing literature, speak to the importance of a connected relation between students and teacher. Creation of a safe learning environment in the clinical area requires that students feel cared-for. It is the sense of being cared-for that encourages and supports students to deliver nursing care in a caring manner. The importance of this relationship between teacher and student requires teachers to be consciously aware of the powerful influence of their actions and behaviours. Faculty development that supports teachers in gaining an understanding of the changing relation between teacher and students and enhances caring pedagogical practices needs to be continuous. There also needs to be additional exploration regarding the nature of

teaching/learning and pedagogical relations within this curriculum.

Attention must also be paid to the choice of clinical placements. Students place a great emphasis on their relationship with staff nurses. Feeling cared for by clinicians on the units assists the students to feel comfortable and consequently facilitates their learning. Clinical placements which offer desirable client experiences in a milieu of disinterest on the part of staff nurses creates a less than satisfactory learning environment. Consequently, education of staff nurses is also a necessary component for the development of a nurturing clinical learning environment.

Presently, a breakfast meeting is held with the members of each term and delegates from the clinical practice areas at the beginning of each semester. These meetings, where the curriculum is explained and discussed, tend to be poorly attended by unit nurses. Their lack of participation, however, may be due to factors other than lack of interest. The working environment of unit nurses is strenuous and stressful. It is often difficult to arrange coverage for a client assignment to attend a meeting. Time off is zealously guarded. It cannot be expected that days off be given up to attend a meeting. The commitment and participation of clinicians is, however, necessary. As indicated by this study and others, the modelling of caring

by clinicians profoundly effects students. Consequently, innovative ways of educating and involving unit nurses in the curriculum need to be explored and implemented.

Involvement of unit nurses might also assist them to consciously renew them commitment to caring relations with clients and other health care professionals. This is also an area that requires investigation. There is little work done on the thoughts, feelings or perspectives of staff nurses related to their interactions with students. As well, there is little information regarding what clinicians feel they need, in terms of material or human resources, to develop a connected relation with students.

Caring practices cannot be taught by content. Rather, caring is learned experientially. It is only possible to learn about caring in an environment that supports and nurtures the connected relation between teacher and students, between staff nurse and students, and between client and students. The students expressions of learning about caring in this study provide some insight into that experiential learning process. The tensions and contradictions related to learning about caring raised by the students, however, are not well discussed within the literature. Further study about these tensions is required so that we may better facilitate the teaching/learning process about caring.

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Appendix A

An Invitation to Participate

I am conducting a study about the experiences of nursing students related to caring. I would like to ask you to participate. I am interested in knowing how you think and feel about the notion of caring. I would like to interview you about your experiences and discuss how you perceive caring. I would also like to review your journal.

The following list outlines the events of the study:

1) I would like to photocopy your complete journal from this semester. I will be reviewing the information in journals for common themes. Your original journal will be returned to you within one week of my receiving it.

2) a minimum of one audio-taped interview will be required. The interview will require approximately 60-90 minutes of your time. We will arrange to meet at a time and place convenient for you.

3) once the interview is transcribed, I will provide you with a copy for editing and comments. If you would like a second interview to clarify any issues that may be arranged, or you may prefer to submit your comments in writing. I will contact you within one week of your receiving the transcription to determine your preference.

This study is being conducted in partial requirement for a Masters of Arts degree. When the thesis is complete, the audio-tapes, photocopied journal entries, original transcripts and computer discs will be destroyed. At no time, will any names appear in any published or unpublished material. No original material or information will be shared with other Langara College instructors without your written permission.

You are welcome to a copy of the final document. Please let me know if you would like a copy and I will ensure that you receive one.

Participation in this study will in no way affect your academic progress. You may refuse to answer any questions or withdraw from the study at any time, without prejudice.

If you are interested in participating please call Wanda Pierson at 420-7858. In my absence, please leave your name and number on my answering machine and I will return your call.

Thank you for your time.

Wanda Pierson

Appendix B

Consent Form

I _____ agree to participate in the study conducted by Wanda Pierson. I understand that I will be interviewed about my perceptions and experiences during my nursing practice experience. I understand that my participation will involve at least one audio-taped interview. I am aware that the time required for the interview will be about one and half hours. I understand that my clinical journal for this semester will be photocopied and the original journal returned to me.

I understand that I am under no obligation to participate in this study, that I may refuse to answer any questions, and that I may withdraw, at any time, without prejudice.

I understand that this research is being conducted to meet the requirements of a Masters Thesis. I understand that my name will not appear on any document, nor will my name appear in any published or unpublished materials. I also understand that original material will be shared with other college faculty only with my written permission.

I am aware that the original audio-tape, photocopied journal entries, transcripts and computer discs will be destroyed at the end of the study.

I understand that I may request a copy of the final document for myself.

If at any time you are concerned about how this research is being conducted, please contact Dr. M. Manley-Casimir, Director of Graduate Program, Faculty of Eduction, Simon Fraser University, at 291-4787.

This study has been adequately explained to me and I have received an information letter and a copy of this consent form.

Signed_____   _____

Date_____   Wanda Pierson - 420-7858

Appendix C

Journal Learning Activities

January 24, 1994

The journals, were for the most part well written. Please try to remember to include a decision you made as part of your journal.

This week I would also like to record one "caring" episode that you witness. Describe why you believe that what you saw demonstrated caring. Note who was involved and what happened.

February 7, 1994

Thank you for sharing your thoughts in your journals. For the next two weeks in your journals please continue to include a challenging decision. As well, I would like you to describe a caring incident in which you are involved.

I would also like you to identify some of the major problems/issues that you encounter in your day-to-day practice.

What do you think are your strongest points in nursing practice?

February 21, 1994

This week in your journals I would like you to write your definition of caring. Look back in your journals and note what you have described as caring behaviour. How do you know when you see caring? What qualities or actions are present?

I would like you to continue to document a challenging decision. Also continue to document caring situations in which you are involved.
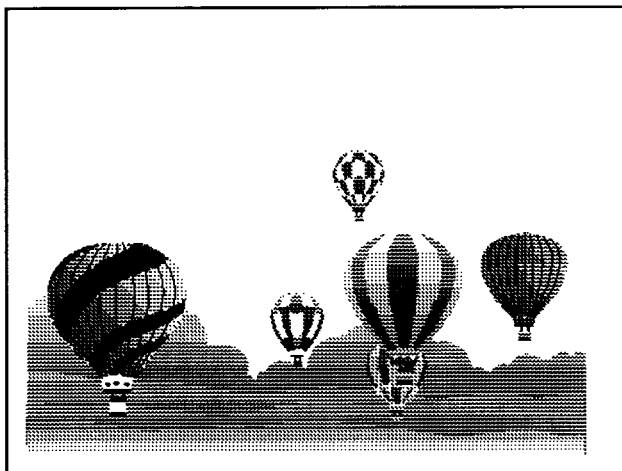
For your journals this week, please contine to include a description of a challenging decision, in which you were involved.

As well, continue to identify a caring situation in which you were involved. When describing the situation, please identify how you felt at the time, and how you feel now that you are reflecting on the situation.

Spend some time thinking about your nursing practice. You might consider the following questions.

What are my skills and talents?

What are my areas of knowledge and experience?

What is my most important achievement?

If you are comfortable sharing this information, please include it in your journal.