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The Lived Experience of Caring and Knowing in Senior Nursing Students

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THE LIVED EXPERIENCE OF CARING AND KNOWING IN SENIOR NURSING STUDENTS

by

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Center for Teaching and Learning

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This dissertation, submitted by Sherry Neil-Urban in partial fulfillment of the requirements for the degree of Doctor of Philosophy from the University of North Dakota, has been read by the faculty advisory committee under whom the work has been done and is hereby approved.

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Signature Sherry Reil-Urban

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ABSTRACT

Caring is identified as a central and defining feature of professional nursing. Yet, there is little explicit emphasis on the philosophy and substance of caring in the traditional nursing program. Rather, caring is subsumed by the pressing need to stay current with expanding definitions of nursing competence and increased knowledge required by licensing boards. The purpose of this phenomenological investigation was to better understand the lived experiences of caring and knowing as expressed by senior nursing students near completion of the nursing program. Eighteen senior nursing students, within one month of graduation, participated in this interview study in which they were asked to describe themselves in the nursing role and to focus on particular interactions they have experienced with patients.

Descriptions of caring behaviors identified by students included listening empathy, helping, being with, not rushing, being competent, genuineness, physical comforting, touch, communication, teaching, seeing or creating positive results, and patient advocacy.

Most students described the progression from fear and anxiety in the initial days of patient care to more security in their nursing practice by the time of this study. Some students spoke with greater richness and more detail about their caring interactions with patents. These "green thumb" caring qualities expressed by roughly half of the students included: reverence for the patient, making a difference by maintaining hopeful

possibility and a commitment to the patient's well-being, personal involvement, and participating in a reciprocal relationship with the patient.

Students who did not express caring occasions in as much detail and did not have recollections of patients in which they were able to articulate interpersonal care were, in most cases, found to express insecurity of either a personal nature or insecurity in the concepts and procedures involved in professional nursing. A minor theme among this group of nursing students was a pre-occupation with procedures, pathophysiology, and technology.

Implications for improving nursing student self-confidence, self-esteem, and caring behaviors are presented. In summary, these implications are for more reflective teaching and learning in nursing education, modeling of caring behaviors by faculty, both in their interactions with students and with patients, empowering student nurses in their developing nursing practice, providing more clinical time in which students have experience with, and responsibility for, patient care, and using teaching methods which provide students the opportunity to understand the human experiences of caring and suffering through literature and the arts.

PREFACE

Personal Note

My interest in caring has been spurred by the large volume of nursing literature on caring. This caring literature has promulgated even more writing from nurse educators who propose a "revolution in nursing education" in which caring becomes central. My reading led to alternating positions of acceptance (even enthusiasm) and skepticism. Is caring the essence of nursing? There are those who argue that it is not (Olson, 1993; and Morse, Bottoroff, Neander & Solberg, 1991). I genuinely believe it is; however, I also believe the medical care system works against such a moral stance. The shear emphasis on tasks and procedures, the mandate to "follow the doctors order," the workload, and the low status of nurses undermines the intent and ability to care. In conditions such as the ones mentioned, I believe it is possible to stop caring. Some have termed this burn-out.

I began to think about my own experiences with caring and its evolution, waxing and waning. In an effort to come clean, as it were, about my potential biases, I will describe my own experiences of caring while learning.

As an antecedent to professional caring I developed the capacity to empathize. I was a youngster who did not "fit in" and I came into the world with a cleft lip and palate. I had some emotional problems which developed as a result of being "different". Eventually, I resolved much of the hurt, despair and hopelessness I had about being what I thought was an unattractive girl in a society which valued only attractiveness in girls. But the effects of such a difficult process engendered in me a capacity to be empathic.

I went off to college and was involved in the usual concerns of trying to do well in my courses, get dates, and work. Being accepted into nursing school was a matter of

course. I can't remember any moments of care in which there was some "inter-subjective larger than the whole" experience while I was a nursing student. I remember being afraid I would somehow do something wrong in clinicals and get caught by the instructor. There are actually only a couple of patients who stand out.

One patient who stands out was a sixteen year old newly diagnosed quadriplegic boy. I was grief stricken most of the two days I took care of him. I frankly didn't know what to say. Interestingly, he just wanted to listen to a heavy metal song entitled "Now I am comfortably numb." He kept asking me to play this over and over. I was stunned and shocked. I tried to be nice. But I had no clue what to ask, or how to begin to comfort this poor boy. Eight years later when my brother became a quadriplegic I was also grief stricken, but I had a better idea of how to comfort, what to say and what might instill hope. I observed experienced nurses in the spinal cord injury center who were incredibly wonderful to my brother and helped him see his opportunities. They had mastered the art of caring in their particular setting. My brother knew at some level he would be all right, in part, because they knew how to open possibilities in a way that I couldn't eight years earlier. I propose that inexperience was the main culprit, certainly not lack of caring. I simply did not have the ability to express anything more than politeness. I have often wondered about the quadriplegic young man. I wish now, as I wished then, that I could have reached out to him.

The next phase of my development as a caring nurse came as my clinical competence improved. Within four or five months of practice as a staff nurse I had lost a great deal of self-consciousness about my abilities as a practitioner, although there were many things I was still learning. I began to feel empowered to express caring. In fact, I saw it as my responsibility to let my patients know I cared for them. I began to "own" my practice as a nurse.

However, I would have to say that the overload of patients and the constant under staffing was greatly straining to my ability to be caring. During the first two years of nursing I can remember many patients and many instances of interconnected caring. Eventually, however, the strain of overload and desire to work exclusively with children led me to pediatric critical care.

Again, I was new in the pediatric intensive care setting and had so much to learn. I was assigned a preceptor and began enrichment courses in pediatric monitoring, use of Swans Ganz catheters, use of mechanical ventilation and the intricacies of pediatric assessment in the critical care setting. Once again, I became a novice nurse.

I love children. I always wanted to be a nurse so I could work with children. But during the time of my orientation, I was blocked from my experience of caring for children and their families. I was self-consciously working at becoming competent in this new setting. Once again, I had more questions than answers. At that point in time, if I were asked the degree to which I cared for these intensely ill children, I would have answered that I cared for them greatly. But my ability to engage myself in a caring posture was subsumed by my need to understand the therapies and the nursing responsibilities. It wasn't a question of not caring; I could not look at the child on the ventilator and not feel empathy, however mostly what I was looking at was the ventilator. How did it work? How do I suction the child on a ventilator? What do the alarms mean? When do I notify the doctor or respiratory therapist there is a problem? And, so forth. It was not until I understood those things that I could effectively care for the child -- the whole child and his/her family.

Weeks, maybe months, later in the pediatric intensive care unit I again began to own my practice. I was able to express my natural desire to care for babies, children and families. Many of the most touching experiences I have had as a nurse came from that pediatric intensive care setting.

My own experience has been that in situations where I have felt my need to learn I have had a more difficult time expressing care in the sense of an emotion or feeling, or an intent to help another. I have instead been self consciously attempting to "make sense" of the environment and the new responsibilities. My personal experience is consistent with Watson's call for knowledge as a presupposition for care (1988).

These, of course, are my experiences. I have made every effort to bracket these ideas, so that the interviews of students were not affected by my own experiences. In the semi-structured interview, I gave students ample opportunity to describe caring interactions they have had with patients in as much detail as they were able.

CHAPTER ONE

INTRODUCTION

Nursing is both a science and an art which requires an ability to make competent clinical judgments while engaged in transpersonal caring for others (Watson, 1987). This creative discipline involves the rigors of science and the aesthetics of caring. Helping nursing students develop a philosophy of caring is the concern of many nurse educators, yet this concern is subsumed by the effort to keep up with the evolving theoretical knowledge and clinical expertise needed in order to become a professional nurse.

Watson (1938) states that caring is the "moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity. Caring is more than just an emotion, concern, attitude, or benevolent desire; it involves values, a will and a commitment to care" (p.29). Leininger (1984) elaborates that care (in nursing) is different from, but complimentary to, the science and practice of cure (medicine). With the increasing emphasis on the technologic approaches involved in curing, or seeking cure, the humanistic emphasis of caring may be lost. Watson (1988 & 1989), Leininger (1990) and Bevis (1989) have expressed concern that without more emphasis on care in the education of nurses, nursing as a caring profession is in danger.

Benner (1990) and Watson (1985) have posed that there is a movement out of an era in which curing has been dominant into an era in which caring must take precedence. This evolving paradigm from cure to care has generated a "curriculum revolution" (National League for Nursing, 1988) about which a series of books and articles have recently been written (Allen, 1990; Bevis & Watson, 1989; Chinn, 1991; Diekelmann, 1988; Leininger & Watson, 1990; Moccia, 1990; Neil & Watts, 1991; Tanner, 1990; and

de Tornyay, 1990). This shift focuses away from the traditional emphasis on content and more on the process of becoming a caring professional (Boykin & Schoenhofer, 1990; Watson, 1988b). To be a caring professional means to practice in a way that is not only technically correct but morally compassionate. Empirical knowledge, while necessary, is not sufficient (Thompson, 1985).

Although caring is integral to nursing, knowledge is paramount; together they constitute humanistic nursing competence. There are two basic constructs of nursing knowledge; the "knowing that" and the "knowing how" (Benner, 1984). Knowing-that refers to conceptual knowledge necessary for understanding diagnosis, pathophysiology, pharmacology, nutrition, biology, psychology and treatment modalities. Carper (1978) refers to this as empirical knowledge which is factual, objectively descriptive and generaiizeable. Know-how refers to the ability to perform nursing procedures properly and as painlessly as possible. This procedural know-how is commonly referred to by students as "skills to learn." This type of know how which makes it possible for nurses to perform procedures as painlessly as possible and provide nursing care that is effective and satisfying is referred to as aesthetic knowing by Carper (1978). Both knowing-that and know-how are essential for nursing which is increasingly technical. Much of the nursing curriculum is based on teaching the "knowing that", or empirics, of nursing. This process involves, to a large extent, the cognitive domain.

Nursing objectives are written according to the cognitive domains delineated by Bloom (1956) who, in hierarchical manner, identifies the levels of cognitive function, which are knowledge, comprehension, application, analysis, synthesis, and evaluation. By the senior year in nursing school, it is expected that the majority of examinations focus on analysis, synthesis and evaluation. Inherent in the nursing process is the ability to utilize higher order thinking skills. The nursing process consists of: a) assessment, b)

diagnosis of the problem, c) goal setting or planning, d) implementation of nursing action and finally, e) evaluation and revision of the plan. Bloom's Taxonomy and the nursing process apply to the essential knowledge base, the "know-that" and the "know-how" of nursing practice.

The other defining professional characteristic caring, is the third leg of the triad. Caring is part of the personal knowing component of nursing which "involves the interactions, relationships, and transactions between the nurse and patient-client" (Carper, 1978, p.18). Knowing-that, the empirics of nursing; knowing-how, the aesthetics of nursing; and caring, the personal knowledge domain of nursing, comprise the fundamental requirements for professional nursing. With the onslaught of technology and the emphasis in nursing education on "knowing what one is doing" it is theoretically possible to be knowledgeable and uncaring at the same time. Without caring, nursing is not a humanistic professional service, but a series of mechanistic tasks.

One could conceptualize caring as a "heart thing" and knowledge as a "head thing" that operate independently. Or, one could conceptualize caring and knowing as discrete ends of a spectrum of behaviors and responses. Instead, Benner and Wrubel (1989) conceptualize caring as that which fuses thought, feeling, and action: it fuses knowing and being and is primary to our existence. Watson (1988) also refuses to dichotomize caring and knowing and asserts that the professional nurse is both knowledgeable and caring simultaneously. Gaut (1986) further contends that knowledge is the basis for professional caring. The question is how do senior nursing students describe knowing and caring in their own nursing practice? The question arises in response to the predominate focus of nursing education which is based in the cognitive and psychomotor domains. The greatest emphasis by teachers is on teaching the necessary concepts and promoting higher order thinking skills; the "knowing that" of

nursing, whereas clinical experiences account for what students feel is the most important aspect of nursing education because of their need to "know how" (Field, Gallman, Nicholson & Dreher, 1984). As a distant third place, caring receives little more than implicit treatment in nursing education. While nursing is ostensibly defined as a caring profession, there is no overt curriculum consigned to the philosophy or ethics of care in the vast majority of nursing programs. It is admittedly questionable if caring can be overtly taught, although there is an emerging pedagogy of care in the nursing literature which claims to revitalize the ethic of care among its students (Bevis, 1989; Boykin & Schoenhofer, 1990; Leininger & Watson, 1990; Moccia, 1990; National League for Nursing, 1988).

How, therefore, do student nurses describe their caring practices with patients? Do they speak in terms of procedural care, or can they describe the more empathic qualities involved? If caring is a pre-existing ethic or philosophy, does caring become subsumed by the effort to become knowledgeable in the nursing process? Is knowing-that and knowing-how the preoccupation of nursing students on their road to clinical competence? In short, what place does interpersonal caring hold for nursing students?

To begin to explore these questions I will examine the nursing students' "lived experiences" of caring and clinical competence. Understanding the experiences of students as they develop professional identities should be an important component in determining the quality of the nursing curriculum, and ultimately in making curricular decisions. If nursing education is to achieve its goal of producing professional nurses, those who can work effectively in complex technological environments while being able to humanize these environments by caring, then it is important to understand the place of caring in the experiences of students with their patients.

Research Question

What is the role of empathic, interpersonal caring in the experiences of nursing students with their patients? Are students able to express care beyond procedural giving of services? Since the focus of much of what is explicitly taught in the nursing curriculum has to do with content, or knowing, it would be expected that students might describe more what they know, or what they can do, in the clinical area, and less about interpersonal caring. In short, this study seeks to understand the essence(s) of the interaction between student and patient.

Problem Statement

What we do know about the experience of interpersonal caring between nurses and patients comes from theoretical constructs of caring and phenomenological studies of experienced nurses. We have sparse and grossly incomplete data on the development of professional caring from its inception during nursing school. Since nursing students are at the very beginning of their professional identity, it is important to start at that point in looking at the development of professional care. Certainly I am not saying that caring begins in nursing school. I am saying, however, by definition, professional caring begins in nursing school. We know very little about the experience of caring between nursing students and their patients. To date there have been two studies using the writing samples of nursing students who were asked to describe a caring experience with their patients (Beck, 1992, 1993).

This study attempts to fill the gap in the literature on the essence of the nursing student - patient interaction. This study will reveal the extent to which senior nursing students, near graduation, experience interpersonal caring and can express this. At this point nursing students have experienced nursing in a variety of settings and circumstances

and are considered advanced beginners by Patricia Benner (1984). This is proposed as one study in a series of three similar studies. The three interviews will be conducted over a two year period to determine the actual development of professional caring for these participants. No such follow-up studies have been conducted.

However, for the purpose of this study I will be describing the essence of the student nurse - patient interaction in the beginning stages of professional nursing development. It is through this study that nurse educators will have the opportunity to evaluate if the philosophy and the phenomenon of caring are stressed adequately in the curriculum.

Assumptions

The following basic assumptions underlie this research:

1. Lived experience is reality.
2. A person can explain what his, or her, experience has been in a reflective manner.
3. A person is the only one who can explain to anyone else what his, or her, experience has been.
4. A volunteer participant would more readily explain to someone else what their experience has been than one who has been required to share his, or her, experience.

Limitations

This study may be limited by the fact that students are neither accustomed nor trained to give this kind of information and may have difficulty verbalizing their lived experience of caring and knowing in their role as nursing student.

While every effort will be made to eliminate researcher bias it must be acknowledged that qualitative research is subjective. Qualitative research deals in essences and language. In qualitative research it is the subjective experience that is of importance, it is therefore subject to misinterpretation. For this reason I have taken steps to mitigate against this possibility. I used a pilot to "run through" the analysis; I relied on the input of a seven member research group for verification of themes; and I bracketed my own biases with regards to the experience of caring and knowing in nursing.

Delimitations

This study is delimited by the fact that only generic senior nursing students from The University of Mary were interviewed. This researcher makes no assumptions about the generalizability of the findings in this study to other baccalaureate nursing students.

A further delimitation of this study is that students were asked to describe interactions they encountered with patients as a one on one experience. This line of questioning necessarily precludes any discussion about relating to, or with, groups, communities or other health care populations. In keeping with the interpersonal model of caring, students did not have opportunity to elaborate on their roles of the nurse as organizer/manager, health educator or as one who works with populations. The role of the nursing student as described in this study is one who provides care for individuals. This study would not be indicative of the lived experience of a nursing student dealing with community based populations.

Definitions

Caring moment, or caring occasion: A moment or occasion in which two persons experience a caring transaction (Watson, 1988, p.58).

Caring: Defies singular definitions. Is a complex construct which is used in the language rather loosely. In this paper caring will be further clarified with added terms of expressive, empathic, interpersonal, transpersonal, and connected; and contrasted with terms such as technical, procedural and instrumental care. Unless caring is specifically referred to as procedural, instrumental, or technical, caring should be interpreted as empathic, or expressive care.

Empathy: Part of the complex construct of caring is understood as an active, imaginative understanding of another's feelings (Montgomery, 1993, p.21).

Procedural care: Instramental care; and Technical care: for the purposes of this research will refer to the "know how" Benner (1984) describes. Procedural, instramental, or technical care-giving may or may not be accompanied by interpersonal caring. They may, or may not be described as a "caring moment."

Intersubjectivity: A human to human relationship in which one person (e.g. the nurse) affects and is affected by the person of the other (Watson, 1988, p.58).

Reciprocity: Is synonymous with mutuality and refers to a mutual exchange, an action or relation given in return, or feeling in return (March, 1990, p.51).

Clinical judgment: The "know that" and "know how" of nursing practice. This term will be used to mean knowledge in the clinical setting.

Traditional age nursing students: Senior nursing students who are between twenty-one and twenty-three years of age.

Non-traditional age nursing students: Senior nursing students who are significantly older than traditional age nursing students.

A nursing program: An educational program which is preparing students to perform all the roles, functions, and responsibilities of a professional nurse.

Traditional curriculum: The planned and guided learning experiences and intended learning outcomes, formulated through the systematic reconstruction of knowledge and experience. Traditional curriculums rely on Tylerian behaviorism in the construction of goals, measurable objectives, learning activities, and evaluation methods (Bevis, 1989).

Reconceptualized curriculum: This is a movement in the nursing literature which seeks to promote a caring emphasis and caring curriculum in nursing education among other things. It has been referred to as the "curriculum revolution" (Bevis, 1989; Leininger & Watson, 1990; Moccia, 1990; National League for Nursing, 1988).

Lived experience: A person's perception of reality; one's life-world. The sense of meaning that persons give to their own situation.

CHAPTER TWO

REVIEW OF THE LITERATURE

Nursing Knowledge

Barbara Carper, in 1978, defined what she called the four fundamental patterns of knowing in nursing. These patterns are 1) empirical knowing, which consists of the objective concepts and theories in nursing; 2) aesthetic knowing, which is the art of providing nursing that is effective and satisfying; 3) personal knowing, which entails knowing the interpersonal processes involved in nursing; and 4) ethical knowing, which refers to the involvement of nurses in making moral choices.

Patricia Benner (1984) conceptualized nursing knowledge in the more basic terminology of "knowing-that" and "knowing-how." Knowing-that is equivalent to Carper's empirical knowledge and knowing-how involves the aesthetic domain.

Nursing practice requires both knowing-that and knowing-how as a pre-requisite to skilled action in the care of others. It is entirely possible for nurses to "know that" and not have sufficient "know how." Reports of clinical inadequacy among new graduates have been made by numerous nurse managers and new graduates themselves (Kramer, 1974; Field, Gallman, Nicholson, & Dreher 1984). In large part, the curriculum is shaped around developing the knowledge base for the profession. The move from the hospital-based nursing program to the university-based nursing program has caused a focus on more academics and less clinical time. Sweeney, Hedstrom and O'Malley (1982) state there is a considerable discrepancy between what skills students acquire in their educational programs and what is expected of them in the real-life job market.

Benner (1984) looked at the evolution of expertise in clinical nursing practice. She based her research on a model of skill acquisition developed by Dreyfus and Dreyfus (1980) who postulated five stages of skill acquisition: novice, advanced beginner, competent, proficient, and expert. Benner stated that the recently graduated nursing student would be at the advanced beginner level of skill acquisition. The advanced beginner is defined as "one who can demonstrate marginally acceptable performance; one who has coped with enough real situations to note the recurring aspects of the situation" (p.22). The marginal level of performance alluded to in Benner's definition implies that advanced beginners need further training. Benner concluded from her phenomenological study of nurses that it typically takes about two years of full-time employment in a given setting to achieve competence.

Historical Background on the Study of Caring

Milton Mayeroff (1971) was the first contemporary writer and philosopher to examine interpersonal caring. His purpose was to remove caring from its association with terms such as wishing well, liking, and having an interest in what happens to another. Mayeroff defined caring as a process in which the object is to help another grow and actualize him/herself. Mayeroff wrote that the central aim for the caregiver is the growth of the other, however by helping the other grow, the one caring is also actualized. Caring, according to Mayeroff, allows one to live out the meaning of his [her] own life.

Heidegger's (1972) perspective on caring is that it is an essential aspect of human being and becoming. Heidegger's philosophical assertion is that care unifies actuality and possibility. In the Heideggerian sense, care is essentially beingness. Caring occurs as two beings presence themselves with one another.

It was not until Nel Noddings (1984) wrote Caring: A feminine approach to ethics and moral development that caring received further attention outside of nursing. Noddings also constructed care as a solely interpersonal enterprise. Noddings views caring as a feminine mode of being (for men and women) which is characterized by receptivity, relatedness, and responsiveness. Caring involves a "feeling with" the other, but more than simply feeling, caring involves a "motivational shift" which incorporates a thinking mode and "moves the self toward the object" (p.33). Care is presented as the arousal of an emotional state rather than that of an analytical, cognitive state.

Noddings argues to move what she refers to as "natural caring" into an ethic of care. She postulates that the "caring attitude lies at the heart of all ethical behavior" (p.92). The ethic of care is a term which originated with Noddings.

In the meantime, Madeleine Leininger then nursing professor at the University of Colorado had been giving special lectures and seminars on caring at a time when there was virtually no literature on caring in nursing. Her efforts in nursing education pre-date Mayeroff's (1971) writings. During the 1976 American Nurses Convention in New Jersey, Leininger presented a program on caring as the essence of nursing. This program was very well received by nurses and nurse educators. The general enthusiasm for the subject and the recognition of the need for further examination, explication and research on caring led Leininger to initiate and Chair the annual National Caring Conferences for three years. Some of the original participants in these conferences including Madeleine Leininger have since become prominent writers on caring in nursing. These participants include Em Olivia Bevis, Kathryn Gardner, Delores Gaut, Rosemarie Parse, Marilyn Ray, Jean Watson and Erlinda Wheeler (Leininger, 1981).

The major goals of the conference were:

1. Identification of major philosophical, epistemological, and professional dimensions of caring to advance the body of knowledge that constitutes nursing.
2. Explication of the nature, scope, functions, and structure of care and its relationship to nursing care.
3. Explication of the major components, processes, and patterns of care or caring in relationship to nursing care from a transcultural perspective.
4. Stimulation of nurses and others to systematically investigate care or caring in nursing.

These conferences were facilitated to produce a "think-tank" construction of theory on caring and sharing of research. This general exploration of scholarly ideas about caring led to diverse and multidimensional definitions or understandings of caring in nursing.

Prior to the mid 1970's, there was virtually no specific focus on caring phenomena and its relationship to nursing care. Since the National Caring Conferences there has been a shift from the study of medical diseases, symptoms and curing to the study of various aspects of caring in nursing.

Perspectives on Caring in Nursing

Leininger, who began the surge of interest in caring in nursing, asserts that care is the essence and unifying theme characterizing nursing. Caring has been discussed in psychosocial, philosophical and anthropological terms by nurse educators. Ultimately the overlapping and complimentary definitions of care confuse the meaning of care for the reader. However, the definitions of care espoused by most nurse theorists/authors include the concepts of human to human connection, an intention to help, and authentic presence

with another. Some authors have further delineated that professional care incorporates knowledge. The psychosocial, anthropological, philosophical, and action dimensions of caring are presented in the following paragraphs.

Watson (1985, 1988, 1989) describes caring as the ethical and moral ideal of nursing. Caring, according to Watson, consists of basic processes between people which result in some sense of satisfaction often associated with human needs. Her psychosocial approach to caring involves transpersonal, intersubjective attempts to protect, enhance, and preserve humanity and human dignity by helping people to find meaning in their illness, suffering, pain, and existence (Watson, 1988, 1989).

Leininger's background in anthropology led her to examine caring as a mode of human action and relatedness that was essential to human existence. She asserts that caring was critical to the survival of the race amid adverse and changing environments and in relation to changes in the cultural, social, political and economic factors (1981, 1985). While care has been understudied in historical and pre-historical times Leininger argues that without care whole cultures would have become extinct. Further, Leininger posits the need for nurses to become culturally adept, because while caring is a universal phenomenon its expressions vary across cultures (1985). This represents the anthropological view of caring.

The philosophical approach to caring is best described in the words of Roach (1984) who expresses caring as "the human mode of being." Roach draws upon the philosophical works of Heidegger. Essential to Roach's thinking is the notion that the desire to care is human and that the capacity to care, like other capacities, must be affirmed and actualized. Caring in nursing, according to Roach, is manifested through compassion, competence, confidence, conscience and commitment. Ray (1981) and Bevis (1981) express care as that which promotes growth, and view it as a form of love.

Gaut (1986) identified three necessary conditions whereby an action could be described as caring: a) knowledge about the client to identify the need for care and knowledge about what to do, b) implementing an action, or series of actions, based on knowledge, and c) evaluating the action in terms of the client's welfare or benefit. Gaut ties knowledge to caring and has a strong action component to caring, as do many of the caring proponents. When asked if caring about the plight of the homeless while doing nothing is really caring, the answer according to all of the authors cited except Heidegger is NO.

According to each of the authors cited, caring is effectively "practiced" interpersonally when the nurse is a co-participant in the process. However, in yet another view, caring is removed from a strictly interpersonal realm and is presented as a necessary central moral construct in the social and political fabric of our society (Tronto, 1993). In this view care is seen as a powerful, yet devalued aspect of human life which must become valued and centralized in social and political values. Tronto (1993) describes four phases of public caring; (1) caring about, as in recognizing the need; (2) taking care of by providing the means; (3) care-giving in the form of direct hands-on care and (4) care receiving. In nursing the primary roles of the nurse and patient are care-giving and care-receiving. The public discussion of care-taking, or providing the means for health care is currently on-going and entrenched in the "Health Care Reform" debate.

For the purpose of this study, the ideal of caring is the human-to-human, subject-to-subject transaction. In "the caring moment" the importance of authentic presence and connectedness with the other is stressed (Mayeroff, 1971; Noddings, 1984; Parse, 1981; Roach, 1984; Watson, 1985). One very poignant example of this connection is told by Phyllis Updike when she describes an experience she had outside the World Health

Organization office in Manila when she came upon a small boy who lay seemingly lifeless on hot concrete (1991):

> As I looked at him I saw that he was my own son. It was not that the boy reminded me of my son. No. He had become my son. I looked and I saw my own boy. I thought he would die if I didn't reach him in time.
>
> I had to get to him immediately.
>
> I knelt down next to him. My boy, my own. Suddenly I felt the penetration of the experience of motherhood from a global point of view. This boy, all boys, all children were mine, my responsibility. I reached out to pick him up, to hold him close to me.
>
> Then.... I looked into the face of this woman. ... I should explain as I began to re-enter this reality from an altered state of consciousness.... She nodded and seemed to acknowledge my unusual intrusion. She seemed to say, "It's all right. I'll take care of him. Don't worry".

Updike went on to explain that this profound experience forever changed her consciousness. She then understood the world and its inhabitants as one family. Her capacity to care and engage herself in the problems of the world had grown.

The actual caring occasion leads to discovery of self (Watson, 1989). In every human to human event there is the potential for caring. This caring moment becomes part of the life of each person and provides the opportunity to grow (Watson, 1985, 1988).

Professional values that support an ethic of care include formation of a humanistic-altruistic outlook, as well as kindness, concern, love, and respect for self and others. Watson (1979) identified ten carative factors for understanding nursing as the science of caring:

1. The formation of a humanistic-altruistic system of values.
2. The instillation of faith-hope.
3. The cultivation of sensitivity to one's self and to others.
4. The development of a helping-trust relationship.
5. The promotion and acceptance of the expression of positive and negative feelings.
6. The systematic use of the scientific problem solving method for decision making.
7. The promotion of interpersonal teaching-learning.
8. The provision for a supportive, protective, and(or) corrective mental, physical, socio-cultural, and spiritual environment.
9. Assistance with the gratification of human needs.
10. The allowance for existential-phenomenological forces.

This science of caring combines science with humanism. For Watson, caring and knowing are interwoven aspects of nursing. In Denver, Colorado, the Center for Human Caring, founded by Jean Watson, uses these ten carative factors as an organizing framework for their nursing practice. Interestingly, they have added an eleventh carative factor called "medically supportive care" in order to categorize and document supportive treatments such as administration of medications and other treatments (Schroeder & Maeve, 1992). The framework created by Watson so much de-emphasizes technical care or procedural care that without modification it could not be used by nurses in a clinical setting.

Patricia Benner and Judith Wrubel (1989) use the word caring to mean being connected, to have things matter. Benner and Wrubel state that "caring sets up what matters, it creates possibility, it creates connection and concern, it creates the actual sharing of help, allowing one to give and allowing the other to receive" (p. 12).

Nurses' and Patients' Perceptions of Nurses' Caring Behaviors

Caring, much like love, defies a singular definition and its experience is perception bound. Further, perceptions of care vary according to the person being asked based on the need they have in that moment. Studies have shown a discrepancy between what patients and nurses have defined as the most important caring behaviors exhibited by nurses. Nurses consistently select listening as the priority caring behavior (Gardner & Wheeler, 1981; Larson, 1986; Mayer, 1987; Wolf, 1988). Empathy, concern and allowing patients to express feelings are all highly ranked by nurses (Bowman, 1987; Gardner & Wheeler, 1981).

Patients in critical care or medical surgical settings are more inclined to view caring behaviors as the ability to provide competent technical care over the interpersonal approaches (Brown, 1986; Scharf & Caley, 1993). Recently, however, patients in an AIDS nursing care center stated the number one priority as interpersonal-relational concerns. They discussed acceptance, unconditional support, hugs and touch, listening and supporting their autonomy as most important caring behaviors (Schroeder & Maeve, 1992). The perception of care is clearly dependent upon the setting, the conditions, or needs, of the patients. But in no way is one perception of care adequate or exclusive.

The Experience of Caring Among Practicing Registered Nurses

Responding to recent theorizing about caring from nurse philosophers, Forrest (1988) recognized the need for study among practicing nurses in clinical settings. Her phenomenological study involved seventeen hospital staff nurses who described their experiences of caring. For these practicing nurses caring is "first and foremost a mental and emotional presence that evolves from deep feelings for the patient's experience." Forrest also described a preference on the part of the nurses interviewed for "being-with" rather than "doing-to" a patient. Yet, when patients were considered "hard to care for," "doing-to" offered protection from the demands of caring.

Kahn and Steeves (1988) interviewed twenty-five experienced nurses asking them to describe the nurse-patient relationship through the use of stories from their practice. These stories illustrated the presence or absence of caring. An interesting finding in this study is that the majority of the informants expressed "liking" the patient as the basis for caring. This finding was distressing to Jean Watson who responded (1988c) by saying how the process of "liking as linked to caring is most problematic and paradoxical" (p.217). According to Watson, the notion of caring as a moral ideal "has nothing to do with liking or disliking a patient" (p.220).

In a phenomenological study of twenty nurses by Green-Hernandez (1991) the question of caring as an intentional professional process or a spontaneous human response was examined. Six themes occurred as natural, or spontaneous caring descriptors, and fourteen themes were revealed as professional caring. While there was overlap in themes for both spontaneous and professional caring, the aspect of intentionality was distinct to professional caring. Green-Hernandez found that the lived experience of natural caring was a necessary antecedent to the nurses' ability to practice professional caring. However, Green-Hernandez clarifies that professional caring is not

simply an extension of caring, rather it is an intentional process in which specific therapeutic behaviors are employed. Relevant to the interest in the lived experience of caring among nursing students is Green-Hernandez's finding that direct and intentional caring was not practiced among the twelve nurses she interviewed when they were new graduates.

Linda Postlethwaite (1990) describes her personal journey to look at herself and her development as a person and a nurse. She uses the metaphor of a plant from germination through bearing fruit. The germination of her caring ethic begins when she was a pre-teenager and through her teenage years. Interestingly, she describes the period of her nurses training as one in which her "caring seed became encapsulated and went into incubation as [she] focused on technical, task-oriented skills and pathology" (p.270). In this period she describes her sense of caring as "flat". She went on to develop caring through the contemporary ideologies of therapeutic touch, and holistic approaches to nursing care and pain management, through her lived experience.

Postlethwaite joins Forrest, Green-Hernandez, and many others in calling for an emphasis of care in the curriculum for nursing students. In addition, they suggest there should be research to explore methods for developing caring while in nursing school.

Nursing Students and Caring

The literature review revealed only two studies that examined the caring of nursing students. These studies were conducted by Beck (1992; 1993). In her first study Beck investigated the meaning of caring for thirty-six nursing students working with physically and mentally handicapped children through analysis of writing samples describing the experience. Six constituents of caring relationships emerged: authentic

presencing, physical connectedness, reciprocal sharing, delightful merriment, bolstered self-esteem, and an unanticipated self-transformation.

In her most recent published study, Beck (1993) analyzed the written descriptions of care by twenty-two undergraduate students. Five themes of caring emerged: authentic presence, competence, emotional support, physical comforting, and positive consequences.

In these studies, the only common constituent was 'authentic presencing'. This fact provides more evidence that care constituents are defined by the context, the needs of the individuals, and the role of the caregiver(s).

Tommie Nelms (1990) studied the "lived experiences of nursing education" in which she interviewed seventeen students across three levels of the baccalaureate nursing program about the experience of being a nursing student. In this study, care did not emerge as a theme, however, personal knowledge did. Students had great concern about developing their knowledge base and felt successful and confident when they were able to experience that they "knew something well" emphasizing the 'knowing-that' principle of the standard nursing curriculum.

Nursing Education

Caring as an interpersonal phenomenon or a philosophy is not explicitly emphasized in traditional nursing curricula; rather it is implicit in the teaching of the methods and procedures of caring <u>for</u> a patient. Further, it is hoped that care is modeled by faculty. Montagu (1958) stated that the influence of the teacher acts as an instrument to lead and allow for the growth of the student. However, as a curricular issue, care is not present to any significant degree. In the Slevin and Harter study (1987), only 8.5% of the schools reported that care was a major concept or organizing theme. Students are taught

some degree of interpersonal skills, and much clinical knowledge about the health care of human beings, but less about the philosophy of care, culture of care, and the substance of care. Symanski (1990) calls for a study to validate the ways care is and is not being taught in nursing programs. Many contemporary nursing writers suggest an increasing emphasis on care in undergraduate nursing education through course work, through a reframing of traditional vocabulary in nursing to emphasize the caring component and by providing a caring and empowering educational environment in which to learn. For instance, advocacy could be discussed in terms of its caring features and the way in which it relates to a philosophy of care.

It is suggested that perhaps there has been an over-reliance on the scientific process (translated as the nursing process) in which "problem solving is based on linearity, rationality and observability" (Watson, 1988, p.22). The imperative in nursing is that nursing education become more sensitized to how professional nursing caring is being conceptualized, taught and practiced in nursing curricula. According to Gaut (1981), "The question of degrees of competence in caring has strong implications for evaluation of student performance as the educator asks, 'What makes S more able to care for X than for T to care for X? Can T be taught to care for X?'" (p.56). Hence, understanding students' comfort with caring and ability to express care for patients has educational implications for nurse educators.

Significance of the Study

This study seeks to fill the gap in the literature about the essence of the interaction between senior nursing students and their patients. Currently this relationship is unexplored. Further, understanding the extent to which empathic, interpersonal caring is present, or not present, in the interactions of students and patients will help nursing

educators evaluate if the substance and philosophy of care should be emphasized to a greater extent and how this might be accomplished.

Description of the University of Mary Nursing Program

The University of Mary is a Catholic, Benedictine, private college with twenty-two majors and twenty four minors serving just under two thousand students annually. About eighty to ninety students at the University of Mary are graduated annually from the Division of Nursing.

The University of Mary offers a traditional generic nursing program which accepts sixty (plus or minus a few) students each year into the junior level program. These students, to qualify for admission, must have taken all of the pre-requisite courses with satisfactory grades. (See Appendix A for the list of required courses for the nursing major.)

In addition, the University of Mary provides a program which educates associate degree registered nurses and licensed practical nurses so that they may obtain a baccalaureate in nursing degree.

The philosophy statement for the division of nursing asserts that:

"The professional nurse educated in the Benedictine tradition not only develops expertise in the practice of nursing but also thinks critically, communicates effectively, responds to beauty, expresses moral values in behavior, exercises stewardship of the environment, and demonstrates an ability to relate to others in an atmosphere of mutual respect based on the inherent worth and dignity of human persons, an atmosphere wherein 'all are welcomed as Christ.'

Benedictine values of community, stability, mindfulness and hospitality are the soul of the philosophy of the Division of Nursing. The Division measures its

effectiveness by the manner in which these values pervade Division activities and by the degree to which the graduates of the Division demonstrate commitment to professional ideals (stability), maintain balance and harmony in their lives (mindfulness), and welcome others with an open heart (hospitality)."

(Baccalaureate Nursing Student Handbook, p. 1-2, 1993).

By the time of the interview for this study which was conducted just weeks before graduation from nursing school, the students have experienced the full range of curricular opportunities and assignments in which patient/client contact was mandatory. These patient care or other clinical experiences are in addition to nursing courses which do not have a clinical component e.g. Foundations of Nursing (N202), Basic Pharmacology (N317), Basic Nutrition (N316), Skills for Nursing Practice (N301), Concepts and Issues in Nursing (N302), The Research Process (N401), and a Management in Nursing (N402) course. The clinical courses in which students participate in patient care or coordination of care and services are described below:

NUR 303 NURSING CARE OF WOMEN AND CHILDREN

The student will apply the nursing process in providing nursing care for the woman, her family, and the newborn during a normal pregnancy, from conception through labor and delivery and into the post-partum period. Common complications in each phase of the cycle will be studied as well as alterations in women's gynecologic system functioning.

Nursing care of children includes health promotion, disease prevention, high risk infant, as well as alterations in cardiac, hematologic, gastrointestinal, genitourinal,

respiratory, musculoskeletal, immunity and inflammation, and neurologic functions.

The student provides nursing care in hospital and community settings.

NUR 305 NURSING CARE OF THE ADULT

This course addresses nursing care of adult clients who experience common alterations in bio-psycho-social-spiritual needs. Clinical experiences are conducted on the surgical care floor, the surgery areas, and the psychiatric facility.

NUR 407 COMPLEX CLINICAL PROBLEMS

Complex clinical problems focuses on the nursing process and its application to adult clients undergoing multiple and complex alterations of processes in the various spheres of holistic integration. Emphasis is on the care of clients with acute and chronic conditions receiving care in specialized institutions or units in the acute and long term care setting. Specifically, alterations in areas of oxygenation, fluid and electrolyte balance, regulation, the immune system, integration, and cell reproduction are addressed. Rehabilitative and gerontological content is integrated throughout the course.

NUR 409 COMMUNITY HEALTH NURSING

This course focuses on the nursing process and its application to community health with increasing emphasis on health promotion and health maintenance of aggregates/populations. The synthesis of nursing theories and public health theories and principles will provide the basis of the course. Working out of a variety of community health-mental health settings, the student will have an opportunity to gain increasing knowledge of community health nursing organization and practice. Issues related to the health of communities at large as well as high risk populations will be analyzed.

CHAPTER THREE

METHODOLOGY

Overview

The method for this study is necessarily phenomenological; the intent is to go beyond the particularities of experience into the meaning and perception of experience. My purpose was to come to an appreciation for the ways in which senior nursing students experience caring for patients. This is a little understood phenomenon, the essence of which is bound up in the ability to verbalize the experience. By simply categorizing, tabulating, or otherwise quantifying experience, some element of its essence is lost.

Phenomenology attempts to explicate the meanings as we live them in our every day existence. This manner of human science also assumes that human experience is always more complex and ineffable than can be fully described. Hermeneutics is a necessary compliment to phenomenology because while phenomenology describes how one orients to lived experience, hermeneutics allows for the interpretation of what has been stated (Van Manen, 1990). Together phenomenology and hermeneutics seek to understand the human experience by revealing meaning through description and interpretation.

Human experience is made up of mind, consciousness, values, feelings, emotions, actions, and purposes which find their meaning in language. The open-ended and probing interview is one way in which to reveal the language and meanings of experience (Husserl, 1982; Van Manen, 1990). The interview is dialogical in nature which is

described by Parse (1987) as a shared discussion of the phenomenon between the researcher and the participant.

Hermeneutics and phenomenology are human science approaches which are rooted in philosophy. Phenomenology asks for the very nature of a phenomenon, for that which makes a some-"thing" what it is (Husserl, 1982; Merleau-Ponty, 1962). The universal essence of something may only be grasped through a study of the particulars as they are encountered in lived experience (Van Manen, 1990). This understanding is made possible through language. Language reveals meaning. The concern is to render lived experience intelligible since this is where meaning resides (Heidegger, 1962). Van Manen says the "essence or nature of an experience has been adequately described in language if the description awakens us to the lived quality and significance of the experience in a fuller or deeper manner" (p.10).

Hermeneutics comes from the Greek verb "hermeneuein", which translated means "to interpret". In phenomenological research hermeneutics has its place in that it serves to provide explanation of what has already been "said". This explanation is both translation and interpretation, in the sense of bringing-to-understanding. According to Heidegger (1968), the mere fact of using language is hermeneutics. Language is interpretation, in addition, any insight the researcher brings to the text is further interpretation. Phenomenology asks, "What is this or that kind of experience like?" Hermeneutics asks, "So, what does this mean?" (Van Manen, 1990).

My intention is to reveal and interpret the lived experience of senior nursing students with particular respect to caring for patients. The focus is on how students experience caring and knowing moments.

Procedure

The main thrust of this work will be the analysis and interpretation of the interviews of eighteen senior nursing students. Interviews are regarded as sufficient (Heidegger, 1962; Seidman, 1993; Van Manen, 1990), and often, necessary ways to gather narrative material which are then used to develop a richer and deeper understanding of something, and a way to get at the meaning of an experience for the interviewees (Heidegger, 1962; Husserl, 1913/82; Merleau-Ponty, 1962; Van Manen, 1990).

An open-ended interview guide was developed and distributed to experts for review. The reviewers included: practicing nurses, nursing educators, nursing students, qualitative researchers and members of my graduate committee. The interview guide was modified accordingly (Appendix B).

Gaining Entry

Approval of the research project was sought and obtained from the University of North Dakota Institutional Research Board. In addition, endorsement from the Nursing Division Chairperson and the cooperating teacher was obtained along with permission from the University of Mary Institutional Research Board. The University of Mary was chosen as the study site for its accessibility and interest in the study.

Senior nursing students were solicited from the nursing management seminar. A brief explanation was given, essentially stating:

> My purpose is to better understand the nature of the interaction between nursing students and their patients. In particular, I am interested in having you describe interactions you have had with your patients in the clinical setting, and in addition I am interested in the process you have undergone to develop your nursing competence.

Following that I read the consent form out loud so that students would have a fuller understanding of their rights and expectations (Appendix C). Students were made aware that the their interviews would be taped and transcribed by myself. Further, these transcripts will be identified only as "Interview 1" or "Interview 2" and so forth. A copy of the students names and corresponding numbers will be kept, along with the audiotapes, in a locked file in my personal home office for at least one year following the interview. Following that, the materials will be destroyed. They were also made aware that, when it seemed appropriate to use names in the manuscript, pseudonyms would be used. Further, I contracted to avoid any conversations about them by name during and following this study.

Because the students were interviewed within weeks of graduation risks to their status in the nursing program were minimal because transcription and analysis would not occur until the summer of 1994 after students graduated. So the potential of the data having any affect on their graduation or experience as a student at the University of Mary was small. Additionally, students were informed that they would be given opportunity to confirm, or disagree with the synthesis of their transcripts before its inclusion into the text of the dissertation. Lastly, students were made aware that they could withdraw from participation at any time without any adverse consequence.

The potential benefits were discussed in terms of their participation providing insight about the nature of the student nurse - patient interaction. In addition, students were encouraged by the opportunity to reflect on their own professional nursing development and educational experiences.

At this point, a list was circulated and students were asked to indicate their phone number and the best time(s) to reach them by phone. Twenty students agreed to participate. Fifteen volunteers were women and five were men. I contacted the volunteers to set up the time and the place for the interview. Students were told the

process would take about one to two hours. At the beginning of the interview, each student was asked to read the consent, to ask any questions of interest, and to sign the consent if it met with their approval.

Pilot

Initially, five students were contacted for interview as part of a pilot to further refine the questions and establish the interview process. After signing the consent they were interviewed using a semi-structured format. Personal life stories or incidences were used as text so that specific, non-vague, examples could emerge. In dialogical manner, the participants were asked to explore their experiences in the clinical setting while working with patients during their time as a nursing student. Once a specific incidence was identified I tried to stay close to the experience and explore the incident, or situation to the fullest as recommended by Max Van Manen (1990). Stories and life experiences served as a resource for developing a richer understanding of the interrelationship between caring and knowing for nursing students.

Following each interview I reflected on how well the questions "worked" and in particular I tried to discover what was missing in the data, or how I could have asked questions in a better way. Upon realizing that the five interviews were so thorough and very adequately spoke to the issue of student nurse-patient interactions, the data from these "pilot" interviews was incorporated into the study. The study was enlarged to include the five "pilot interviews." The total interview sample was twenty, two of which were later dropped from the study due to an inaudible tape or not meeting the requirement of being near completion of the nursing program.

I established the process for synthesizing and coding the data while analysing the interviews. Each interview was audio taped and transcribed. (Appendix D provides an example of one such interview.) I carefully read and re-read the transcripts for meaning

and for themes. When there was need for clarification or "hearing the participants voice" the audio tape was played while the transcript was read. From each fifteen to twenty-eight page transcript a two to three page synthesis was created and themes were identified. The process of synthesis comes from Seidman (1994) who recommends writing a third person narrative of the interview or series of interviews and Parse's (1987) discussion on "extracted essences" which involves writing a third person account staying close to the language of the speaker and emphasizing core ideas in the words of the participants.

Analysis included: a) a production of a list of words/phrases that each participant used synonymously with caring along with contextual descriptions; b) the collection of clinical exemplars or prototypical examples of caring offered by participants; and c) the effects of nurses training on the development of patient care. An example of one synthesis is provided in Appendix E.

Participants were contacted to verify, clarify, or dispute the synthesis and list of themes. In each case confirmation was made.

Sample

Following the process of interviewing the first five volunteers and establishing the process for analysis, I began interviewing the remaining fifteen nursing student volunteers. Two of the volunteers were eliminated from the study. In one case, the student was more than one semester from graduating, rather than within a month of graduation. In the other case, the student's voice was too soft to be audio taped. Again, the total number of accepted participants was eighteen. Once more, consents were signed, the audio tapes were transcribed and syntheses of the transcripts were developed. Followed by student contact for confirmation of the synthesis.

The description of the participants follows:

Table 1.
Description of Participants

GENDER:	Thirteen female Five male	
ETHNICITY:	Euro-American	
AGE:	(21 - 23)	9
	(24 - 30)	2
	(31 - 35)	5
	(36 - 40)	0
	(41 - 45)	2
	Total	18
GRADUATION STATUS:	All expected to graduate within two to four weeks.	

Analysis

The data (transcripts) were analyzed from three perspectives. First, using the process described above, each transcript was analyzed individually and synthesized for meaning and for themes. Identifying themes was a way of getting at the central content of a description, or to give shape to something that appeared shapeless. A theme is a form of "capturing the phenomenon one is trying to understand" (Van Manen, 1990, p.87). Then, as mentioned earlier, confirmation was sought from the participants. Each participant was contacted for either telephone or in-person confirmation of the synthesis and themes. The participants heard the synthesis and were asked to add any correction, disagreement, or additional insight to the synthesis. Confirmation was obtained from all eighteen of the participants.

Second, the transcripts were coded. Each transcript was read, line for line, and sentence for sentence, to identify the meaning or the code for each statement or paragraph. The code names were written in the margins. When the coding of all of the eighteen transcripts was complete, envelopes were created with code names as labels. Examples were terms like "being with," "not rushing," "motivation to be a nurse," and so forth. The codes were put into the envelopes for quick access when discussing the findings.

The third perspective sought was from the research group of which I was a member. The research group consisted of eight participants interested in hermeneutic and qualitative research. The members were five female graduate students in counseling, or clinical psychology, one occupational therapy faculty member and one counseling faculty member. Each member read a total of four transcripts; three transcripts represented the essences present when caring was well articulated and richly experienced by the participants; one transcript was "flat" by comparison and caring was not clearly articulated. These were two distinct experiences and provided defining examples of the phenomena I was describing and interpreting.

During different sessions we would discuss the themes and the insights the group discovered concerning an interview transcript. Similarities and differences between the texts were discussed and recurring themes were linked to common meanings. The discussion of the group confirmed my initial impressions and interpretations of the transcripts and added more insight and alternative views.

Finally, researcher interpretations were brought back to the group and were shared for further discussion and confirmation. The research group process involved a complete loop from reading transcripts to discussing and interpreting findings and finally, reviewing the developing document for clarity and accuracy.

The three perspectives, (1) synthesis of the whole transcript and revealing themes followed by student confirmation, (2) coding each transcript line by line, and finally (3) discussing select transcripts with members of a research group provided complimentary appraoches to understanding the data. These complimentary perspectives served to give me a more thorough sense of the participants and their lived experience.

CHAPTER FOUR

FINDINGS AND DISCUSSION

Immersing myself in the interview transcripts was a rewarding experience both personally and professionally. Through the lived experience of using the phenomenological method the beauty of caring and developing professional competence for nursing students was made tangible.

The findings will be presented in seven sections. In the first section, I will introduce nursing as a profession in which 'presencing self' is a prefatory requirement for satisfactory practice. In the second section, I will describe the themes that emerged from students' descriptions of themselves and caring behaviors they use in working with patients. In the third section, I will describe the caring phenomenon as it was expressed by nursing students who were particularly expressive of caring. These nursing students described caring within the context of an experience with a patient. It is from these students I learned perhaps the most about the nature of a caring relationship between a student nurse and a patient. In the fourth section, I will discuss the themes in the transcripts where caring was not richly articulated. It is from these students that I draw the most compelling inferences for nurse educators. In the fifth section, I will look at the relationship of professional caring and knowing from the perspectives of the students interviewed. For nursing students knowledge is imbedded in the ability to care for patients. "Knowing moments," and moments of competence in the clinical setting will run throughout the discussion on caring. I will also address the benefits of caring from the perspective of nursing students, or nurses, and the perspective of patients.

Lastly, and as a separate subset, I will address the issues that were particularly relevant to the men I interviewed. In as much as women represent a minority in the computer sciences, men are still a minority in nursing. There are sparse studies of men in nursing or male nursing students, and while I have included their input and insights throughout this document, it is enlightening to cluster these students separately for the purpose of underscoring some of the particularities of these men in nursing school.

Presencing Self

Many of the students said, in one way or another that nursing is much more than a job. Indeed, nursing is more than a job because it involves the use of one's very self. Like so many of the helping professions i.e. social work, teaching, and counseling, nursing is not limited to a single or even dual domain, but rather requires the use of the whole person. In particular, nursing involves the ability to bring presence forward for the purpose of connecting with the patient. It is this connection that gives meaning and provides the greatest source of satisfaction for nurses, and indeed, for patients. Anyone who has practiced nursing for any period of time can recall times of personal involvement with patients that really mattered to them and to their patients. These are moments that stand out as important, as meaningful and as powerful. These are times when self was used as a conduit, a vehicle by which something positive could be gained for patients. For some, the use of self and the ability to presence self flows so naturally that it looks as if the ability must be automatic, easy, comfortable and natural. While it appears that presencing self must be something that happens easily from the start, the findings in this particular study indicate that presencing self evolves and follows a developmental process.

What is this "self" to which I am referring? Self is that context of one's humanness; the ground of being that gives rise to our thoughts, feelings, and actions. Carl

Jung (1964) called it part of the collective unconscious. Martha Rogers (1970), who developed perhaps the most complex of all the nursing theories, describes persons as energy fields. 'Self' is more than our personality or our professional identity, it is much broader. The self should be thought of in metaphysical terms; some would refer to the self as the spirit within each of us. In any case, the being or the self I am referring to would encompass any of the definitions of spirit, energy field, or collective unconscious.

Presence is described by Martin Buber (1878 - 1965), an existentialist philosopher, as an intersubjective "between of human encounters." (Buber, 1958; 1965). According to Buber (1958; 1965), this between is the genuine relational response characterized by openness, mutuality, and presence which provides meaning to existence. The between is described by Buber (1958) as an "I-Thou" encounter which is focused on the present and involves sharing the self. In this experience there is genuine listening where persons enter into each others being and sense unity. In contrast, the "I-it" encounter focuses on preconceived expectations of past experience and involves withholding of self.

Presence, according to nurse researcher Fredricka Gilge (1992), is "an intersubjective and intrasubjective energy exchange with a person, place, object, thought, feeling, or belief that transforms sensory stimuli, imagination, memory, or intuition into a perceived meaningful experience" (p.61). Further, Gilge (1992) described the consequences of presence when she wrote "an experience with presence may result in an experience of love, hope, transpersonal caring, self-disclosure, and expansion of consciousness... lingering presence, intuitive knowledge, advocacy, and healing" (p.61).

The findings in this study indicate that the ability to presence self, in a face to face interaction with another individual, does not spring up naturally, at least not in the early stages of developing professionally. For nursing students, this ability involves a growing process that usually begins with fear. Very few students can identify the cause of their

fear when they began floor nursing, but virtually every student interviewed described their first contacts with patients in the hospital as fearful. One student identified this fear quite extraordinarily when he said "It's such foreign territory. You're not used to bathing someone. You're not used to that type of personal relationship in offering care. It's being face to face all day with one person. [It] has a way of frightening people." Several students identified the fear as "not wanting to do harm to a patient or endanger patients." Although, in the first day(s), students are simply asked to introduce themselves to patients and provide basic care such as offering a bath. Some students said they were "scared to death" because they felt they did not know enough to be in the hospital caring for patients. It must be readily apparent that in the throws of sheer fear it would be impossible to establish any significant rapport unless it was based the patient comforting the student nurse.

Transpersonal caring involves the ability to presence self (Gilge, 1992; Montgomery, 1992) and it does not spring forth automatically. It develops. There are some antecedents to professional caring that seem to be necessary. First, the students must have some comfort with self; who they are at the level of their being. It was clear in the interviews that students who lacked confidence, or described themselves as "shy" had a more difficult time describing a caring moment. Secondly, nursing students must have some degree of self-confidence in their abilities and knowledge as a nurse in order to be fully present in the moment. When nursing students are insecure about the skill, or having the right answers for the patient's questions, then presence is blocked. Thirdly, the motive for caring must come from a desire to help, to sustain, or promote the other. This altruistic motive is fundamental to the ability to engage in a caring posture.

Initially students were asked what motivated them to choose nursing as a career. Sixteen out of the eighteen students said they "wanted to help people", they "cared about people" or they "love working with people" and "making a difference." Altruism is the

most pervasive motivation for becoming a nurse. In only two cases did students express self-interests and fail to express interest in others as a motivational factor. Since motivation is out of the realm of an educator's impact, and since, students generally do enter nursing with an altruistic motive, the more compelling inferences for nurse educators is to improve and increase self-awareness and self-confidence of both a personal and a professional nature. The findings to support such inferences will follow in future sections (pages 75-80). The implications for nurse educators will be the focus of chapter five. Following is the list of themes of caring generated by students when asked to "describe yourself as a nurse" and to complete the sentence... "Some of the ways I express caring in my work are..."

Caring Behaviors

Students were asked to describe themselves as nurses and to describe the way they expressed care in their work with patients. From those questions evolved a list that is consistent with much of the literature on caring behaviors (Beck, 1992; 1993; Bowman, 1987; Gardner & Wheeler, 1981; Larson, 1986; Wolf, 1988) with the exception of "being genuine" which is particular to this study. The list of themes expressed as caring behaviors include: listening, being with, not rushing, being genuine, competence, physical comforting, touch, teaching, positive results, and advocacy. In addition, they commonly interchanged caring with empathy, helping, compassion, and concern. A brief discussion of these findings follows.

Listening

Virtually all students, when asked how they express caring, and when they were asked to describe caring stated listening. Listening was the single strongest theme found among the participants.

Not Rushing

Students felt that patients needed the student's time in order to feel cared about. "Taking my time" and "not rushing" were statements made frequently. Sometimes taking time was put into the context of getting to know the patient. Caring was so often expressed as taking time with, and for, patients that I wondered how these students would feel about themselves as caregivers when they had very little time to spend with individual patients.

Time is a consistent finding in the literature on caring. Studies of patient's perspectives also indicate time is an important variable of caring (Brown, 1986; Scharf & Caley, 1993). The concern is in the way short staffing and high patient acuity mitigates against nurses spending any substantial quantity of time in patients' rooms for the purpose of establishing rapport. In the same manner a high case load decreases the amount of time a community health nurse has to spend with clients in the home. The following theme parallels this one in its implication that time is an important factor in the perception of care from the nurses' as well as the patients' perspective.

Being With

Several students talked about being with patients and staying with them through times when the patients were afraid, or uncomfortable. Being with was most often

expressed in terms of "being there for them to talk to." Although in one case the student did use the term "being present for" the patient.

In the realms of existence; being, doing and having, students who express "being with" are experiencing the ontological sense of being as caring, and caring as being. Heidegger (1962) describes this phenomenon in Being and Time. Whereas, caring also has agency or a "doing" component. This doing component is expressed at times when competence emerges.

Competence

Interestingly, competence was described in caring for patients (listed below) as an emerging element in the care the students were providing for patients. Competence was one aspect of student confidence that was established in some measure over time. Students reported that many of the moments of "being able to pull it all together" came in the last semester. One student put it this way, "[By my last semester] I was just at a level of confidence where I could talk at the same time as providing basic care and it didn't paralyze your mouth because you had to concentrate so heavily on what you were doing." Moments of exhilaration were described by some students when they were able to (1) independently diagnose vasodilation and hypotension and knew how to begin treatment (i.e. put the patient in trendelenberg position and increase the IV rate and call for help); (2) read the heart monitors and understand the pulmonary wedge pressures correctly; (3) perform head to toe physical assessments without the book; (4) answer patient's questions with some degree of confidence and authority; and (5) understand the lab values of a patient in renal failure. When students had moments of insight, or competence, they felt validated in their choice to be a nurse. When doing for, or doing to, a patient brings about some positive result students experience their sense of agency. Agency is the ability to create an effect, or make something happen. Agency was addressed by

Montgomery (1993) as contributing to the curing aspects of patient care and was described as ego gratifying. One student said after she had sucessfully started an IV, "I felt like a real nurse."

Being Genuine

A number of students said "being genuine," or "being yourself" was important in the interaction with patients. Students reflected that one must "know who you are" in order to really be genuine with patients.

This poses an interesting paradox for student nurses who are told they must accept their patients. For some students being genuine would prohibit them from accepting persons with alternative lifestyles such as homosexuality and drug use. Being genuine might also prevent them from acknowledging, much less promoting, a woman's right to an abortion. Perhaps it gets down to how one defines genuiness. If being genuine suggests approaching another human being, regardless of differences, with genuine respect, then genuiness is possible for each student nurse. However, if it is translated to mean being honest and either agreeing or disagreeing with the patient then genuiness would pose a problem for nurses and nursing students everywhere.

Physical Comforting

Some students reported they liked to make the patient comfortable by (1) making sure they had what they needed, (2) by giving back rubs, or combing hair (3) by reassuring the patients about their progress or medical condition, and (4) by relieving their pain. Comfort measures ranged from simple, yet personal, tasks to very important pain relieving measures. For example one student said, "I remember I just stood there and combed and braided her long hair." Another student said, "I want to try to alleviate some of their pain, and some of their mental pain."

Touch

A handful of students reported that they like to use touch as a way to communicate with patients, or comfort them. "Gentle-touch" was the term a few students used when describing touch as a caring behavior. One student described herself as particularly "touchy-feely" and that touching patients comes "very naturally" for her.

Touch was described as simply putting a hand on the patient. This form of touch has no specific purpose other than to comfort a patient, or help a patient relax, or to communicate caring to a patient. Touch should not be confused with physical comforting which refers to meeting the physical needs of a patient. Generally, students who did feel comfortable with use of touch reported that patients responded favorably to touch. A few students discussed the need to be judicious and "see how the patient responds" before assuming physical touch is acceptable.

Teaching

Several students described times when they explained a procedure, a medication, baby care, monitors, or options for a patient. However, teaching was not as strong a theme as listening, being with, comforting the patient or performing procedures adequately perhaps because the participants are student nurses who are unfamiliar with many clinical procedures and hospital protocol. However, students were willing to share information, to teach, when they felt competent. In order to teach something you have to know it first, you have to have seen it once, or more, you have to have some prior experience. Without prior experience there is a great deal of context that is foreign to the student. Students reported feeling uncomfortable when they were expected to teach something they didn't know well. For example, how can a student do "discharge teaching" if she, or he, has never seen a discharge? What about the contextual

information, where to go, and with whom to speak? And, what are normal symptoms verses really serious symptoms for which patients should seek medical care?

Often this kind of information is learned from expeience. As the saying goes, see one, do one, teach one. When students have not "seen one" it is very difficult to "teach one," yet this is the expectation we nurse educators put on the students. Teaching, when the students felt comfortable enough to do it brought some satisfaction to the students who felt that they were making a contribution to the patient. However, teaching, when it was expected as part of the student's responsibility and when the student did not know what to say, was very "nerve wracking" to quote one student.

Many of the students said they felt particularly incompetent to teach in the junior year. One student described trying to conduct [his] duties as a nurse; "In my junior year, I wasn't able to conduct those things and talk at the same time. Like walking and chewing gum at the same time. I'm better at that now [as a senior]."

Positive Results

The point of the care, the teaching, the communicating, the being-with, the listening to, the helping, the whole essence of caring in nursing, is to create some positive benefit for the patient. Students who could actually see positive benefits of their care were greatly pleased. One student stated: "The source of caring for me is my desire to give something away that has a positive result. If I can use myself and my knowledge to assist people, then I've done something worth-while."

Advocacy

Advocacy was described in terms of laying out the options for a patient. For example, some students spoke of helping patients decide which week to go for surgery, or helping them identify their fears, or coming up with solutions together. There were no

instances of advocacy where a student actually intervened on behalf of a patient with a physician. There were no cases of students confronting the system on behalf of their patients. This type of confrontation is also a matter of experience. To advocate for some change, even as minor as a room change, for a patient requires some knowledge of the system and some sense of one's power within the system. It is premature to expect confrontational advocacy from nursing students. Advocacy is a theme for these students, but a minor one.

Common Descriptors for Caring

Students often used other words interchangeably with care, or caring, these words were "concern," "compassion," "helping," and "empathy." Frequently the students stated that they "try to put themselves in the patient's shoes," one student nurse said that she could sometimes actually "feel what the patents were experiencing."

The following themes were identified in the students nurses self descriptions of caring behaviors they exhibit:

Table II.

Descriptions of Caring Identified by Student Nurses

Altruistic Motives	Competence
Concern	Genuineness
Compassion	Physical Comforting
Empathy	Touch
Helping	Communication
Listening	Teaching
Being with	Advocacy
Not rushing	Positive results

An interesting observation came out of these interviews with students. When describing caring behaviors and giving examples of themselves as caregivers, the students focused on individuals who were predominately located in the hospital setting and were experiencing loss of optimal health, and in some cases, were facing an inevitable death. Students did not tend to discuss persons who were healthy and were assisted to maintain their health, as in educating school aged children about healthy eating, or working at a blood pressure screening booth, or any number of other health promotion activities. In only one case, did a student bring up an expectant young woman as someone with whom he had "established a bond" while providing some anticipatory guidance about delivery and subsequent breast feeding. The point is that students tended to respond with care as in a "motivational shift" toward another and an interpersonally rewarding experience when the patient was experiencing some dis-ease, or significant threat to their state of health. The more compelling the state of dis-ease, even to the point of terminal illness, the more likely the student was to bring up the patient as one with who· ·ie/she had connected. It appe·rs that from this interview study that caring was more clearly associated with compelling and dire circumstances. This could be due to the fact that selective memory does not permit persons to recall the less compelling moments of care. Or, perhaps one takes these simple moments of care for granted and therefore not worth mentioning. For example, no one spoke of providing a newborn baby with his/her first bath as a caring moment. Does this not count as "connecting with" or caring in the interpersonal sense? Perhaps it is when circumstances and experiences present themselves as "how it should be" we accept caring as a simple matter of responding to everyday operations. But, when circumstances present themselves as <u>not</u> how they should be, as in the case of a baby who dies, caring stands out as compelling. In the

following sections there will be examples of such compelling stories in the students' lived experiences.

I moved from asking for self description of personal attributes and caring behaviors to having students identify times "when they really connected with patient(s)." This process was richly revealing of the student's engagement in the 'caring moment.' Montgomery (1993) points out that caring has been sentimentalized to mean superficial goodness, compliance, and self-sacrifice. The stories of the caregivers suggest a much more powerful and personal event which involves sophisticated relational and communicative abilities.

I began by asking students to list all of the patients they could remember over the past two years of being a nursing student. I asked them to slowly recall each clinical area and attempt to recall the patients they had taken care of in these areas. They were not expected to remember names but a simple recollection of "the man with the broken hip" was suggested as a way to recall the patients they had cared for. After they had completed the list of patients they were asked to put a mark by the patients that stood out as memorable. Finally, I asked them to select from this shorter list people that "stood out as memorable" or people they "felt they really had a connection with" for further discussion.

I was most struck by the contrast in the students abilities to describe patient interactions and to elaborate on caring moments. Some students in my sample simply could not think of a moment that stood out in the clinical setting other than clinical days which were "fun," or times when they "had a nice day." Yet other nursing students expressed a great deal of care in the way they described their patients and how deeply they were affected by their patients. As I listened to the nursing students who had rich descriptions of care, at some level, I felt that I had been ministered to. And if I, who was not vulnerable, could feel nurtured and engaged by these students, I suspect these same

students could have an even greater effect on their patients who were vulnerable by virtue of their illness and hospitalization.

The Metaphor of "Green Thumb" Nursing Care

I have borrowed the term "green thumb" nursing from Jensen, Back-Pettersson and Segesten (1992), who postulated that some nurses in Sweden were found to intuitively know how to bring about more positive results in their patients than other nurses because they were most adept at the art and practice of caring. In my sample of eighteen senior nursing students I discovered that eight of the eighteen students had a relatively rich vocabulary to describe the ways they cared for patients, the personal satisfaction they received while caring for patients, and their own personal philosophy for caring for patients. In all but two cases the "green thumb" nursing students were significantly older than average (over twenty-eight years of age). The two traditional aged nursing students stood out as remarkable in their sensitivity and their ability to "put themselves in their patients shoes" as compared to their traditional aged peers. One of these students attributed her caring strengths to her faith in God and her loving family. The other traditional aged student described the tremendous joy and satisfaction she received by caring for developmentally disabled or dysphasic patients. It happened that she has a younger sibling who has severe cerebral palsy. She attributes her personal caring ethic to this painful, powerful and rich life changing event. In general, however, traditional aged students do come with an altruistic motive and have been exposed to just as much of the curriculum, but have not developed a rich vocabulary of care at this point in their lives. The missing elements may be life experience and self-awareness coupled with feelings of security. When students were not able to describe caring moments often, instead, they would discuss their insecurity. I cannot eloquently speak to why students

were not expressive of care. I can only describe the variables of care that were present when students could articulate them.

Caring appears to be evolutionary. Students, however altruistic they may be, develop caring as an ethic and as an ability to presence self through multifaceted processes in which they come to know themselves fully and are able to develop an understanding of what it is to be a human being enmeshed in what we call the human condition. It appeared from my sample that the nursing students who have life-experience by virtue of their age and maturity, or by virtue of some important life changing event, usually a crisis, have an unusually high ability to initiate and engage in caring relationships with patients. I should also state that not all students who were older than average were able to speak articulately of caring moments with patients. Age is only one variable, but it is not the decisive factor in the ability to express care.

I want to be clear that I am not saying that there were students who did not care for patients. Clearly the students wanted to be able to help their patients and, in most cases, had some idea of where to start, and what to do. Expressing care and caring are separate phenomenon. Students may care a great deal for their patients and not be able to express this experience articulately. In addition, expressing care is not a discrete phenomenon where one person can articulate care and another person cannot, instead the ability to express care is on a continuum. Some students were very expressive of caring moments, or demonstrated their degree of attachment or involvement with patients as they were describing the experience and other students were not as expressive of care. I will not make the leap to say that any students in my sample did not care, but I did see that the ability to express care was hampered for many of the students.

Fundamental to a caring moment is the ability to presence self. As an antecedent to presencing self the individual must know self, must know how to use self to the best advantage for the patient, and must have some degree of comfort and confidence in self .

Comfort and confidence with self is partly comfort with themselves as individuals but it is also comfort with their ability to perform adequately in the clinical setting (Benner, 1984). Hence, students who feel confident in their knowledge base and have self-confidence will be better able to establish connections with their patients, and patients will have an easier time trusting them as professional caregivers.

The metaphor of a gardener seems particularly relevant to my way of thinking about care. There are some gardeners who just seem to have a natural talent, a green thumb, for making plants grow and flourish. These master gardeners have a lot of wisdom. Their repertoire of knowledge includes things like what to plant, because some plants thrive in hotter or colder climates, when to plant, where to plant, since some plants prefer more or less sun, what fertilizers to use, how much and how often to water, and how to keep the birds, bugs and rodents away from the plants. Any gardener can obtain this information; the green thumb gardener brings something more to the work. Her natural ability, her talent, and her stewardship, in essence, elevate her level of mastery and enhance her know-how.

In the same manner there are some nurses, or nursing students, who have a "green thumb" for caring. That is, they too have the know-how and they have the 'something more.' For instance, they know about the special diet the patient is on, the medications the patient takes, the lab values in the chart, and the background of the patient. They know how to assess the patients' mental status, their physiological status and their social well-being. They know how to do the correct procedures in the correct manner at the proper time(s) . And, nurses with green thumb qualities bring another dimension to their care of patients. Green thumb nurses, and nursing students, stand out as particularly talented at initiating and establishing connections with many of their patients. It could be that what green thumb gardeners and caring "green thumb" nursing students have in

common is love - love of the craft and love of the what, or who, they are caring for (Gilge, 1993; Liehr, 1989).

When I compared the transcripts and the summaries of students I have labeled "green thumb" caregivers with students who do not stand out as having a green thumb for caring, some key distinctions in self descriptions, motivation for choosing nursing, level of self-awareness, and self-confidence materialized. Green thumb care-givers described themselves as "very empathetic," or "compassionate;" sometimes they have used words like "touchy feely." One student said she was the "kind of person who just loves people." The students who were able to describe connecting with their patients also were likely to suspend judgment about their patients and "accept them for who they are," and be able to "walk in their shoes." These green thumb nursing students, in every case, felt nursing was a perfect "fit" for them; that caring for patients gave them opportunities to really "make a difference in someone's life." Making a difference seemed to give these student nurses tremendous satisfaction.

Green thumb caregivers were more likely to express confidence in their evolving development of clinical competence than student nurses who were unable to describe caring interactions with patients. However, it is important to understand that these caring student nurses began with the same measure of fear as many of their peers. One student nurse stated about the first month being in the hospital:

> It was really overwhelming. It was scary. You felt like you had a lot of responsibility and that made you kind of nervous 'cause you didn't know for sure just what you knew and what you were going to do and if it was going to be right. All of the fears that came with the unknown, I guess. But, basically, the feeling like you didn't really know if you belong there and you had the nurses there and you didn't want to get in their way. It was really scary.

> This same nursing student went on to say that by her senior year:
> Things just started connecting, you know, I mean everything just started coming together and you know why things have to be done the way they are. And you know you can do it. You can do the assessments, I mean just off the top of your head, you know, because you have this knowledge behind you, and ah, things just seem to come together as a, as a senior. But it was a gradual process. I really felt a great amount of competency. I really felt like "a nurse," you know, and I never felt that way last year.

This description of evolving skill and concept development is a rather typical description given by students; however, the students with greater comfort in establishing rapport with patients were more likely to express some satisfaction with their level of confidence by the end of their senior year as a nursing student. Some of the other students still felt that they had a long way to go before they would feel like a "real nurse."

Nearly everybody, when asked "what motivated you to choose nursing?" stated in some fashion their desire to help people. Students I would describe as having a green thumb for caring would be much more likely to state things like "I always wanted to be a nurse," or I just knew I would love nursing." One student who was very expressive of his love for his patients described nursing as his "calling."

Repeatedly, when asked what was the foundation for their ability to be caring or how were they able to establish connections with patients, student nurses with green thumb nursing qualities responded that they "really knew themselves", or had "done a lot of self-assessment" and that this self-awareness was a large contributor to their ability to understand patients and what they might be going through. One student stated:

> If you know yourself then you can care. If you can know yourself and you know how you feel and how you react, you show more care than if you, you're still trying to feel out who you are... I think then you don't really care about who the other person is. I think you're more concerned with how you are than how they are.

In summary, nursing students I have characterized as having a green thumb for caring describe themselves in more emotional or personable terms, are motivated to choose nursing because, at some level, relating with patients fits their style and provides enormous satisfaction. These students are generally more self-aware and self-confident than their peers. Again, I am simply characterizing traits some nursing students express in greater measure than others. These traits are on a continuum and are not assumed to be "absent" in any of the students interviewed. The students who do not express these traits to any large degree may not be less caring than their green thumb peers. However, it appears that they may yet develop greater confidence, self-awareness, and the ability to more fully express care.

Caring Identified in the Context of the "Story"

How do students with a green thumb describe their patients, or their relationships with patients that stands out as more caring? In other words, on what basis do I make the claim that some student nurses have green thumb care qualities and are more expressive of care than their peers? The transcripts revealed the following themes... caregivers with a green thumb often (1) express reverence for their patients, often are (2) emotionally, or personally involved with their patients, and have a talent for (3) making a difference with their patients. The difference they make often is based on their commitment to the well-being of the patient and their ability to see beyond the realities of the case or

circumstance and recognize hopeful possibilities for the patient. In addition, a caring interaction between student-nurse and patient involves a sense of reciprocity for both the student and the patient.

Reverence

Green thumb caregivers frequently express reverence for their patients. Commonly, students would well up with tears when they recalled patients with whom they had connected. Reverence is defined as "a feeling or attitude of respect tinged with awe" (Random House, 1986). Students venerate their patients by acknowledging the very personal ways they have been affected by their relationships with their patients. One student, Connie, was describing the very debilitated and painful state of the woman she cared for as a home health aide. This woman had severe rheumatoid arthritis and osteoporosis. She was in a lot of pain and even the simplest of procedures like sponge bathing her would cause tremendous pain. The nursing student spoke of her as "absolutely brilliant" and acknowledged her love of poetry and her love of literature. Connie's focus was very much on the beauty this woman had shared with her. She had deep reverence for her. Now in the last days of this ailing woman's life Connie was able to see past her frailty and acknowledge who she was as a unique person.

Another student, whose pseudonym is Jennifer, was describing the profound love a foster parent had for the multiply handicapped children she cared for. Jennifer was completely struck by her love for these children, tearfully she stated:

> I was just overwhelmed by how she could handle this. This was not the first child she had taken under foster care with major medical problems. So she had seen it [death] before and yet she was willing to do it again. All of these kids had died so she didn't have any more kids, so she took this baby. I was just amazed that she would put herself through these

> emotionally taxing experiences repeatedly. She knew this little baby probably wouldn't make it to his fifth birthday, and yet she was willing to take him in and just love him and care for him. To her this was "her" little boy.

Jennifer added:

> I even asked her why she does this, you know, why do you take in children that are so medically ill? She said "you just have to love them for who they are." "If he smiles a little bit, that's all it takes to make it all worthwhile." She could see beyond what others could see. She could see something deeper and special.

Jennifer recognized this woman's ability to "see something deeper and special." It touched her humanity and brought tears to her eyes.

Tim was describing a patient he had taken care of while on the oncology floor who had just months to live. He was touched by this man's strength and selflessness. Tim stated:

> He realized he didn't have much time left, but he wasn't worried about his life; he was worried about the people he cared about. I guess I learned a lot about ...(pause).... the simplest love is a concerned love. Even though he had what I would consider a devastating situation in his personal life, he had no concern for himself. Quite a man. I wish I could do that, and I'd like to say that I could, but I don't know that I could.

Tim added that he felt a reverence for this man. Here he describes the learning he had received from this man. In his description, he is focused on who the man is and is touched by the perceived courage and selflessness of this man. There is an absence of ego in his words as he says.. "I guess I learned a lot about... (pause)... the simplest love is a concerned love."

Susan described the experience of being on the oncology floor and being with another man who had cancer:

> The best experience I've had so far has been in oncology. Ah, the endurance that these people have, knowing that they have cancer, you know, knowing that it isn't something that is going to be cured. Basically they are in the hospital to die. They know they are going to die there and how they can go on and have such a wonderful attitude and a good sense of humor, and just a love for life, it really, ahm, that really left an impression on me.
>
> Susan began talking about one of the patients she became particularly attached to: (Tears fill her eyes.)
>
> Anybody who came in contact with him would say "what an attitude." This guy was just amazing. I think that everybody who came in contact with him will remember him forever.

Notice again that the stories the students tell focus on the patients. There does not seem to be any personal desire for recognition or ego gratification in their stories. I would say that they were able (like the woman with the handicapped son) "to see something deeper and special." This kind of "deep seeing" is part of recognizing the humanity in the person being cared for. Often students are inspired by patients who have found ways to impart meaning into their illness, or have managed in some way to rise above the illness. Students who observed this phenomenon in their patients often welled up with tears when they recalled these patients. This is an expression of reverence.

Personal or Emotional Involvement

Student nurses with green thumb qualities become personally involved with their patients. Becoming personally involved, or emotionally involved presents a dilemma for nursing students, and for nurses. Professional code suggests that nurses should maintain their distance and not become too close. The term "appropriate boundaries" is used to admonish caregivers from getting "too involved" (Kosowski, 1993; Pascareta & Jacobsen, 1989; Stiver, 1991) yet the nature of an appropriate boundary has yet to be specified. Maslach (1983) recommends adopting the other's perspective rather than feeling the other person's emotions as one way to maintain this separation, but separating emotional from intellectual empathy is impossible in the realities of caregiving (Munley, 1985). It is the nurse who is at the bedside twenty-four hours a day and who keeps the patient alive in critical times. It is the nurse who eases the patients' pains, listens to and addresses their worries, tends to the walking wounded known as the family, then, educates and rehabilitates. In the words of nurse ethicist Leah Curtin, " Of all the professions, nurses perform the most intensely personal services for all people in extraordinarily vulnerable positions. Occasionally we hold a person's life in our hands; almost always his dignity." (Heron, 1994, p.11A) One student described her level of attachment to her patient in these words:

> You just get so latched onto the patient. They always say, "Don't get too involved." That's hard to do sometimes because you do get involved with your patients.

Furthermore, advice which suggests that nurses keep a safe personal distance from patients devalues caring (Morse, Solberg, Neander, Botorff, & Johnson, 1990) and removes the caregiver from the emotional satisfaction that is inherent in meaningful involvements (Benner & Wrubel, 1989).

In any case, the students who were more expressive of care felt personal involvement was part and parcel of what good nursing is. One student said:

> I always feel like when I provide care that is detached, and, that uhm, it wasn't good care ... even if it was professional and it was competent and you did the right things and all that, um... but if my heart wasn't in it ... there was something very important missing.

Susan, who was describing the man she cared for on the oncology floor, described her sense of loss over this man's death.

> I felt a lot of sadness because knowing what, you know, the depression he was going to go through, uhm how he was going to go downhill, and eventually die. I was very, very saddened by that. And tears come to my eyes as we speak. Uhm, I guess (voice is breaking) I just simply have a lot of respect, uhm, a lot of respect for him. I found out he died three weeks later. It just broke my heart.

One student who took care of a little boy who was newly diagnosed with cystic fibrosis reported that:

> The emotional aspects of it [caring] can be very difficult, you know, you get really emotionally attached to a patient and ah, but, you just have to separate that at times. It's O.K. to show emotions to families I believe, but you really have to pull yourself together, because they [the parents] are looking to you to be strong.

Another student described the extent of his emotional involvement over the death of a small baby:

[I was emotionally involved] to the extent of crying myself to sleep at night. Watching a six month old baby die of ----- syndrome. And to see the expression in the little baby's eyes and to see Mom and Dad standing there helpless. And to have to decide "should we let the baby go?" The hardest part was trying to be professional; trying to be a caring professional and trying to, I don't want to say "hold it together," because I can't talk about it yet and not get a lump in my throat. [chokes up] The moment Brandon died he looked up with his big blue eyes at his mom and dad and took one last breath and closed his eyes for eternity. And it chokes me up to think about it because he didn't do anything to deserve to die. (At this point Tim is unable to speak he is so emotional.)

Another student said of her patients:

Sometimes you just feel like taking them under your wings, even though they're sixty or something. You're just taking care of them and you want to take them home and say, "I'll take care of you."

Many of the students talked about crying over patients, and having tears of joy (usually over the birth of a baby). Emotions were experienced willfully by most of the students with rare exception. One man stated he tried to keep his emotions under control because "men just don't do that sort of thing." Two women stated they did not like to express emotion in front of others because they were "shy." However, all of the green thumb nursing students were comfortable with expressions of emotion and seemed appreciative of the experience(s) which were so moving that tears were brought to their eyes. Some expressed this as being "thankful for the personal learning," others expressed

their reverence for patients with tears. Watson (1989) describes the learning in terms of an intersubjectivity. She stated:

> An ideal of intersubjectivity and transcendence is based upon a belief that people learn from each other how to be human by finding their dilemmas in themselves. What is learned from others is self-knowledge. The self learned about or discovered is every self; it is universal, the human self. People learn to recognize themselves in others. The intersubjectivity keeps alive a common humanity (p.180).

Interestingly, in some of the stories the nursing students told, it was clear they experienced love for their patients through the practice of care. Yet only one student used that term. When I shared my interpretation with the students I felt "loved" particular patients in all five cases they responded with a sense of relief. They themselves couldn't use the term, because it simply is not sanctioned in our western, male-prescribed, professional demeanor to acknowledge something as ethereal and as emotional as love. Since "love" in terms of professional experience falls outside of majority professional experience there is no voice for it. The person with the experience is left unable to describe it in professional terms, and if she, or he, is able to identify the phenomenon as love, the admonitions against publicizing this level of sensitivity and involvement would certainly silence such an expression. By acknowledging their level of emotional attachment, the students generally felt that they had been heard.

This degree of emotional attachment is somewhat striking in our culture where the helper is often portrayed as the traditional hero, with the focus on individual achievement rather than on connection with others. Feminist psychology provides insights into the issues of connecting with, as opposed to individuation and separation from, others. Belenky, Clinchy, Goldberg & Tarule (1986), Chodorow (1978), Gilligan

(1982), Jordan (1989), Baker Miller (1976) and others point out that our understanding of relationships and relatedness is limited because existing theories of human development overemphasize issues of autonomy and other values that are more reflective of the masculine experience in our culture.

According to Gilligan (1982), male and female experiences represent different human truths. "The truth for women is to recognize for both sexes the importance throughout life of connection to self and other, the universality of the need for compassion and care" (p.98). Baker Miller (1976) stated, "eventually for many women, the threat of disruption of an affiliation is perceived not just as a loss of the relation but something closer to a total loss of self" (p.83). While male psychological growth has been characterized as developing autonomy by establishing increasing distance from primary love object (mother), females develop a sense of self through identification with the mother, thus their psychology is characterized by relationships and attachments (Chodorow, 1978).

There is growing disagreement that women are more caring, more sensitve to others, and more nurturing than men (Tronto, 1993). Nurses, of both genders, have been found to demonstrate comparable qualities and value affiliation and connection (Carlsson, 1988; Davis-Martin, 1984; Skevington & Dawkes, 1988). In our society, however, the importance of attachments has been minimized in psychological theories that reduce development to increasing separation and independence. Consequently, basic human needs for dependency and deep relational involvements have been infantilized and pathologized (Jordan, 1989).

In any case, the degree of emotional involvement makes the experience of relating with patients more satisfying, but in some cases it can lead to "burn-out" (Bailey, 1985; Maslach, 1983). Some students have thought about this possibility. One woman was talking about the extent she cares for her patients and stated "[sometimes] I do feel a lot

of sadness and I will cry, but I'll go on, I mean it's not something that's going to prevent me from taking care of another person. I guess I just appreciate the lesson they give me in life." Another student stated "it goes back to perspective. I know a lot of people take their work home, but you just can't do that.... But you have to know it's O.K. to grieve and it's O.K. to cry."

In fact, crying imparts to us our humanity. When tears are shed in reverence, in sadness or in simple joy there is something profoundly universal in the experience. It is a spiritual experience. In essence, the indiviudal is connected to the wonder, or the power of an event, a circumstance, or a person. Tears are a powerful reminder of the spiritual nature of our existance and of our shared humaity. Kosowski (1993) calls for a re-evaluation of caring work and respect for tears. In her words, "A humanistic society must invite diverse experiences and expressions of compassionate human involvement -- including the healthy healing waters of emancipated tears" (p. 93).

Making a Difference

The phrase "make a difference" is used frequently by successful caregivers. Montgomery (1992) distinguishes between intent to make a difference and desire to solve all the patients' problems, or meet all of their needs. She claims the desire to meet all of the patients' needs is suggestive of ego involvement and can result in codependent relationships with patients. However, in contrast, an intent to make a difference helps caregivers "focus on discovering possibilities" (p.118) and is not ego driven.

Connie who earlier revered her patient's love of poetry wanted to help her write "whatever poetry was left inside" her before she died. Connie used her own hands as an extension of this women. She carefully transcribed the words this woman softly and deliberately spoke. Connie provided hands for this woman at a time when she could not use her own. Connie helped this woman extend her legacy to her daughters. Perhaps,

more importantly, Connie gave this woman she cared for, and cared about, the most important final gift. She helped her to prepare for her death. She states:

> The lady with rheumatoid arthritis, ... I had, [pause] we had talked about death and what it meant to die, and I guess what I was doing was assessing her readiness for what was to come. She won't live much longer, a couple months, maybe three months. I was just assessing her readiness of where, and if she's, you know, completed things in her life, because if she hasn't I'd like to see if maybe there's something I can do or I can tell the case manager and we can work together on. You know, maybe [pause] she writes poetry, maybe she wants to write more poetry and all she needs is the hands to hold the pencil. I 'll read some poetry to her and that seems to be, it helps her you know, but she can write the best poetry I ever heard. (Sometimes I write the words for her.) By doing this, I'm doing it slowly, through each meeting we assess a little more. 'How are you doing with this and how are you doing with that issue?' So that way maybe we can help her when it does come time for dying -- to make her feel like she's accomplished these things.

Because Connie became personally involved and attached she knew this woman's love for poetry and she wanted to empower her in her final days to do the things she needed to accomplish and to fill her days with what she loved most -- poetry. Connie also related that she had spent time preparing the daughter of this woman for what she would see when she came to visit. The daughter had not been back to see her mother in quite some time and Connie wanted to prepare her [the daughter]so that she would not express shock when she saw her mother. The initiative Connie took in calling the daughter long-distance when she found out the daughter was visiting is yet another example of Connie's determination to make a difference for her patient. Connie sensed

the hopeful possibility when perhaps others would not have. That hopeful possibility is a significant part of making a difference for patients and represents another theme that shows up commonly for nursing students with green thumb characteristics.

Perhaps the most heart wrenching example of a nursing student who became emotionally attached and really made a difference for the mother of an emergency room patient is Melinda, who had been assigned to the emergency room to observe and participate with a nurse preceptor. She had been there only forty minutes when a fifteen year old boy was brought into the emergency room following a car accident. As it turns out the boy was dead on arrival and attempts to revive him failed. The parents arrived shortly after the boy got there. There was confusion initially over the actual identity of this boy. The boy was ultimately identified by the father.

Some time after that, Melinda had to attend a "support group in the community" as part of another course requirement. The students were merely required to attend one meeting to fulfill the assignment. Melinda discovered it was the first night of the six week series called "Good Grief." And since she had been having trouble sleeping at night over this traumatic experience from the emergency room she thought it might be informative and relevant.

It turned out that the mother of this fifteen year old boy who had died was also a member of the class. Further, it turned out that, the two were assigned to the same small group for sharing. They began holding each other and crying, and talking about their mutual feelings of grief over this singular tragic event. Melinda has attended every meeting since for the dual purpose of connecting with Bonnie, the boy's mother, and understanding better the experience of loss. Melinda is concerned about Bonnie's rage and anger and she hopes that by being there, supporting Bonnie the healing process for herself and Bonnie can begin.

Melinda, fully two months after the trauma, carries around a picture of this boy in her wallet. The writing on the back says "To Melinda, I wish Adam could have known you. He would have truly enjoyed your friendship. You are very warm and compassionate. Hope we can keep in touch and be friends. Adam's mom - Bonnie."

Melinda has made a difference in this grieving mother's life. And this experience has made a difference in Melinda's life. She describes the tremendous learning she has had about the depths of pain and grief when tragedy strikes. This relationship has enlarged them both. Melinda will carry this boy in her consciousness forever although she never knew him.

It should also be stated that Melinda recognizes her propensity for over-involvement. She stated that maintaining balance will be important and at the same time "difficult to do." Currently, she states her family, particularly her husband, is very understanding and has helped her work through this emotional experience.

In another compelling story where a nursing student sought to make a difference and did, there was an automobile accident which left a young man semi-comatosed. The students were told he was totally uncommunicative. Her description follows:

> He was in a bad car accident. There were drugs involved and you'd get this from the charts and there was a lot of talk out at the nurses station that said, "Well, this is his own problem, he did it to himself." I was working with another student that day and we were just mad about it, we're like "who cares how it happened, he needs help." We spent a lot of time doing assessments and suctioning him and everything. We would talk with him anytime we were in the room and we washed his hair. I'll bet he hadn't had his hair washed the whole time he was in there. It was so gross, it was just disgusting! He couldn't talk at all or anything but you could just tell that after we were done he was really trying to smile and he was really...

> Then we were visiting with him. We talked with him just like as if he could talk with us, like you learn in school. By the time we left at the end of the second day he said his name to us. And, it was so clear that that's what it was. It was like he was trying to say something so bad. We didn't know, he wanted to say something so bad, we didn't know "should we try to [get him to communicate], or is that just going to frustrate him?" It was like he really wanted to say something and he said his name to us.

Later this student saw him up in the rehabilitation floor and was excited to see that he had made a significant recovery although "he wasn't completely back yet." The difference this student made is that she remained hopeful about his prognosis and she refused to resign herself to the negative connotations about him. She treated him as if he were conscious and treated him with respect. She showed an interest in communicating with him. Not to mention that she made the effort to provide physical care and comfort measures when she washed his hair for the first time since his hospitalization. She had a commitment to his well-being. And, again, hopeful possibility comes through in this scenario.

One student described making a difference as:

> You just give a little bit extra to each patient. One patient had all the cards sitting there and we were talking about the cards and how much they all meant to him and I thought we should hang them up on the wall. So we got some tape and we plastered the whole wall with his cards. The patient thought that was just the greatest thing. I just think it's important to show a little interest in their life and what means something to them or what's special to them. I like to give, just kind of that little individual, personal touch.

Another student made a difference with an eleven year old boy with a severe broken femur while he was working as a nursing assistant on the pediatrics floor.

> [Over time] it developed into a real good relationship. He came to trust me. I never did anything to him without explaining what I was doing. We were both Dodger's fanatics. We both liked the same professional football team. We just had a lot of things in common. We talked about a lot of personal things and I wasn't just "doing my job." I guess the biggest thing that helped with our friendship was the second week that I took care of him I bought him a Dodgers poster. He was asleep when I hung it on the wall. When he woke up he just knew that I was the one who bought it for him. He was really a neat kid. It was a good experience.

In this particular case, the nursing student took a very personal interest in the youngster. They shared a camaraderie and many personal interests. Tim went the extra mile when he purchased a Dodgers poster for the boy. The boy must have felt a sense of special importance when his caregiver showed that much interest in him and took time to show his affection and share his resources with him.

One student was discussing the joy she got by writing the autobiography of a ninety-three year old woman in a convalescent hospital.

> I kind of focused it around the theme of... on her ninetieth birthday she got her first teddy bear and so she said that was when she started her second childhood, cause she got her first teddy bear ever on her ninetieth birthday. So I titled it that, and wrote it as how much she shared with me instead of just this is the order of her life, but how much she shared with me and how much I grew to know and respect her from being able to visit with her. ..... When I gave it to her she was just like, 'You did!! You didn't have to do that.' She was so appreciative.

Making a difference for patients also showed up in the efforts students made to help patients communicate. One student (Paula) relates her personal experience to her ability to work with developmentally delayed individuals. Paula's younger brother has severe cerebral palsy and does not verbalize. She describes his birth as a turning point in her life where she was able to "see through the lens of his experience." Paula has devised ways to communicate with him and understand him. She is able to use this talent and her patience for persons with communication problems. With tremendous satisfaction she speaks of the joy she gets in helping her developmentally delayed patients, and her stroke patients, to speak. At one point, she described a blinking method she devised for a patient she was told was non-communicative. Another student similarly reports the satisfaction of helping dysphasic patients speak and be heard. In these cases the students stretched themselves in order that the other would be heard and know that their thoughts and feelings were important to the student nurses. The satisfaction these two student nurses express is inspiring.

In summary, "making a difference" occurs when there is hopeful possibility and when there is a commitment to the well-being of the patient. In cases where students have made it part of their responsibility to discover what interested the patients and what would brighten their day, patients have expressed gratitude and have felt that they were "special." There are many additional ways that nursing students and nurses make a significant difference to patients. Some of these ways include the empathic listening they do, the teaching they provide, the comforting and encouragement they provide, and the successful completion of tasks and procedures.

Reciprocity

Having stated that green thumb caregivers are inordinately talented at establishing connection with patients it is critical to say that not in all cases can there be transpersonal

caring. The caring moment involves reciprocity. Without a reciprocal interaction between nursing student and patient, caring becomes unidimensional and instrumental. The nurse is in a care-taker role rather than a caring or care-giving role. Without the permission, or the participation of the conscious patient, the nurse, no matter how talented at establishing rapport, is in a situation where she, or he, must simply perform nursing actions in perfunctory manner. In the words of so many nursing students who described the frustration of not being able to make a connection with patients, "you just do the best you can."

Moch and Schafer (1992) define presence as a "process of being available with the whole of oneself and open to the experience of another through a reciprocal interpersonal encounter" (p. 238). How then is reciprocity described by nursing students?

In a caring relationship with a conscious patient both the caregiver and the patient are active participants in creating the relationship, and both are affected by the experience. It is important, however, to state that consciousness on the part of the patient is not essential for caring, as was illustrated by the student who cared for the young man who was said to be "uncommunicative." The nursing student can administer directly to the humanity, or the spirit, of the patient. Her energy, her belief in a hopeful possibility and her desire and interest created, in her mind, a miracle. In his case he actually did reciprocate in a manner that will stand out in her mind forever when he spoke his name. Nonetheless, if he had not spoken, or tried to speak, she was still determined to treat him with dignity, respect and caring. Therefore, the impulse to care does not depend on the participation of the patient, but the unfolding relationship does. One student very eloquently described the nature of a reciprocal student nurse/patient relationship when he explained:

> Any new relationship at any level begins on one side or the other and you can [think of it as] a ladder. What I mean by that is that my placing my hand on one rung would be introducing myself and letting them become familiar with me and placing their hand on the second rung would be them responding in a positive way, and having them tell me a little bit about themselves. And, going to the third rung would be possibly some generalized care and doing some vitals. And that would open it up to the fourth rung. And you climb that ladder of relationship by the way you respond to one another. And, sometimes they just don't respond. So you only make it up the ladder so far.

Still other student nurses simply refer to the ability to establish a connection as a "click" or a "bond." A phrase that describes connecting with patients in the simplest of terms was used commonly with green thumb caregivers is "we just clicked together." And, sometimes they said "we established a bond." Sometimes students used the phrase "interpersonal relationship" to describe the interaction between themselves and their patients.

One student stated, "For the most part, I can always tell like when I walk into a room if I'm going to connect with somebody or not." When asked how she could "tell", she stated:

> Just the look in their eyes. Just the way they respond to you when you say hello. They have a smile on their face, or if... It's just a feeling in the air, you know, I think you can just kind of tell. Like if somebody is scared, I'll hold their hand a lot of times. I can tell if they're going to respond well. They'll like squeeze it back and if they don't respond then I'll let go because I'll know it's not their wishes.

Another student said:

> The interaction that we had between each other. I felt like I was able to interact with these patients more and I felt I was probably able to teach them more and do more things for them than some of the others. They were, they still needed care and still, I was able to provide them with the care, but these ones, *there was just something about them that I just felt closer to them. I don't know how to explain it, it was just something there."* (emphasis added)

According to Watson (1985):

> In a transpersonal caring relationship, a spiritual union occurs between the two persons, where both are capable of transcending self, time, space, and the life history of the other. In other words, the nurse enters into the experience (phenomenal field) of another and the other person enters into the nurse's experience. This shared experience creates its own phenomenal field and becomes part of a larger, deeper, complex pattern of life (pp. 66-67).

Watson's theory (1985) describes caring as a mutual exchange in which both parties relate on the level of their shared humanness, and both learn from each other. Again this is in striking contrast to the notion of professional distance that many caregivers are advised to maintain. The nurse and the patient experience a union at the level of spirit, giving them access to a greater energy that serves as a source of self-renewal and healing (Montgomery, 1992). By incorporating the aspect of spirit Watson and Montgomery shed some light on the potential power of these "caring moments."

Reciprocity is not constituted by the care given but rather manifests itself in the shared meanings between the nursing student and the patient. The shared meaning created is the outcome of a shared encounter. Patricia Marck (1990) has

listed attributes of therapeutic reciprocity. These attributes include mutual self-disclosure, exchange of humor and efforts to enlist client participation in decisions about their care (p.50). Some students brought up the need for humor and experience of "having fun" with patients.

Frequently students will use terms like "the time we had together" or an experience that they "shared"" with the patient. When the nursing students talked about caring occasions, they usually talked about how they were affected by the experience. The reader can recall times of inspiration, reverence, joy, tears and appreciation students have expressed. Sometimes reciprocity on the part of the patient involves the expression of appreciation on the part of the patient, however, paradoxically, appreciation by the patient is not expected. Clearly, appreciation is good for self-esteem and even exhilarating to nursing students, but it is not essential for caring. Connie described a time, after she had taken care of an elderly man for two days, that she was told "My wife and I, we just think you are going to make a wonderful nurse someday." Connie reports that she thought "this is worth it. Not any amount of money could ever been as meaningful. That just made [her] feel like 'yes, this has been so worthwhile.'"

Other students report being thanked for times they helped patients cope with frightening procedures, or times when they simply stayed with them in the hospital. Sometimes the appreciation expressed by patients was inspirational to the student. One student reported: "I just felt like this lady really needs me. She kept saying 'you're coming back aren't you?' So I'd quick go do what I had to do and then I would quick come back and reassure her that I was coming back." In this student's case, she particularly enjoyed the experience of being needed by this patient. If this pattern continues, there is danger that this student may engage in mentality which says: I need you to need me so I will make myself known to you so you can appreciate me. This is a

very different kind of mentality than caring in which the patient and the nurse are working together toward the mutual goal of the patient's well-being and sharing in the human experience.

By and large, students who were thanked by patients were appreciative and gratified. In no way did they feel that the patients owed them a thank you but each thank you was a very memorable moment for the students who are at a time when they are still learning their skills and developing confidence in dealing with patients. "Thank-you"(s) meant the world to them.

In the end, the student nurses will report that the patients "did as much for them as they did for the patients." Some students speak of this as "personal learning" they get by being involved in a caring relationship with a patient. The term "lessons" is used to denote the impact of some patient, or some patient's circumstance on green thumb caregivers. With this sense of reciprocity comes gratitude. Both the student and the patients often express gratitude for having had caring moments with patients.

The Experience of "Not Connecting" with Patients

If the experience of connecting is so mutually gratifying, interpersonally rewarding and energizing, what is the experience of not being able to make a connection? In a word, this experience is frustrating. Interestingly, of the eight students who were expressive of caring moments, only two could "identify a time when they couldn't connect with a patient." In contrast, those who could not describe caring for patients in any compelling detail could usually identify time(s) when they were not able to connect with patient(s).

There were a few overriding themes in the descriptions of not being able to connect with patients. One was that the nursing student was making a judgment about

the patient and the judgment the student was making prevented rapport. Another theme is that student nurses do not like to feel that they are being manipulated by patients. The third inhibitor of student nurse-patient connection has to do with personal characteristics or circumstances of the caregiver, for example tiredness or nervousness. Finally, sometimes patient characteristics block rapport from developing. For example several students reported things like; if the patient is tired and doesn't want to be bothered - you don't pry. One student said that one of her patients was "just downright mean to [her]." And, another student said that "some patients just don't say much, don't communicate with you. It's difficult to understand what they're feeling when they won't tell you."

Feeling Manipulated or Taken Advantage Of

When students have described times when they could not connect with patients, sometimes these scenarios depict some form of manipulation or power struggle. One (green thumb) student stated:

> This lady... I don't want to say she was a bother because nobody is ever a bother. But, I had her at the same time I had a patient who needed a lot of meds, and a lot of care. And she was on her buzzer *constantly* for just little things. "Can you bring me my tissues, can you this and can you that." You know, just little things that if she would have bent over she could have grabbed them herself. I didn't mean to be mean to her, I wasn't snotty, but she expected me to be there with her all the time. I couldn't be. I had to prioritize a little bit. So that was tough. ... She wouldn't smile, she wouldn't talk, she wouldn't say hello. She would answer your questions in yes or no and that was it. It was just really hard.

Actually, there were two dynamics working against a reciprocal and caring interaction. The first was that the patient appeared to be manipulating the student by

making many trivial requests. The second frustration is that it appears she wanted the student in the room but did not want to engage in any kind of interaction. The patient did not appear to respond favorably to the student attempts at conversation. Reciprocity and inter-subjectivity were stymied.

It is possible that with more experience as a practitioner the student will develop the ability to break through communication barriers as the one described. However, it is foolish to think that any nurse can be all things to all people and sometimes it seems the chemistry just is not right. Another student said: "One guy in particular was a really good patient; he's really interesting and nurses had had good talks with him, but yet there was like this space between us. You could never really connect through that. I don't really know why it happened." In a similar vein another student said: "Everybody's different. You're not going to get along with everybody you take care of. Of course you'll care for them but not as strongly as in the same heartfelt way as a patient you click or bond with. You'll still care for them but in a different way - not as strongly."

Judgments about Patients or their Lifestyle

In nursing there is a moral imperative to care for patients even when you do not agree with them or their lifestyle. Sometimes nursing students have been angered by patients and have had to step beyond that and deal with them as valued human beings.

One student described her experience taking care of an alcoholic woman who fell down the stairs in a drunken stupor and broke her leg. Five days later she gave birth to her baby. Apparently this young woman had never had any pre-natal care and was a heavy smoker:

> I guess you kinda have that, 'How could you do this?' You know when there are so many other things that go wrong with babies, the anomalies, and you know the fetal alcohol syndrome, and stuff. I guess when you

think of all the things that the babies go through without adding the alcohol part to it - it kinda makes you angry to think someone would do this while they're pregnant. But, yet you can't judge her, you can't just say, 'Well, how could you do that?' You have to accept her. You have to treat her like anybody else.... I went in there and said, you know, how difficult it must have been to give birth with a cast on, and we talked a little bit and I asked her a couple of questions, like how she broke her leg, and she kinda joked around about how she fell down the stairs. I guess it really didn't bother her. So I didn't want to make it look like I let it bother me. I really didn't have time in four hours to bring up the drinking part. In a way I wish I had had time - I guess you have to build up a closer relationship before you can begin talking about the personal things...(pause). I think you just put people on the defensive when you just jump right in and say, did you know this isn't good, and what you do is alienate them.

Despite her health concerns for the patient and her judgments about the patient's lifestyle, establishing and maintaining a connection was more important to the student nurse than risking alienating her. Caring was motivated principally by the intention to connect with the patient in a way that was helpful. The caring relationship has no agenda other than to connect with the patient. According to Montgomery (1993) "when care-givers relate from the intention to 'connect with' rather than 'do to' a person, the communication can have a healing effect" (p.45). Melinda recognized the value of connecting and did not want to risk that connection by alienating the patient with her judgments and agenda for change.

One student was angered by a young Native American father of three who attempted to take his life but left himself in a comatose state instead.

> Sometimes when I was caring for him, I was angry. You know, for doing it, just like his family was angry that he had caused them all this pain. And now he's going to be there and be basically a vegetable for the rest of his life. There won't be much chance of rehabilitation. But other times, I was feeling sympathy for him and for his family, because his quality of life is definitely going to be decreased. How could he have gotten help to prevent this? And what about his poor family?

At one point she stated:

> I needed to put away my thoughts about Native Americans. Cause you hear all the bad stories about living on the reservation and all that. I had to just get past it. I just had to focus on his care and on his family, especially his mother and his wife who were there all the time. I found myself listening a lot. They still really needed to talk about him. They were really so supportive [of him]. It was just amazing.

Nursing students, like Americans in every walk of life, come with their share of negative cultural stereotypes. What is required of nurses, however, is that they move past these simplistic and superficial, if not utterly false, stereotypes and care for ethnically diverse human beings. This student could have been prevented by her stereotypes about Native Americans from assuming a caring posture, but she "got past it." As a consequence, the family was able to be heard at a time when they needed someone with whom to talk. One student said:

> You just have to get rid of those old misconceptions, you learn to accept people as they are, whether they're gay, or poor, or Native American, or

> they come from another country, or if they've got head lice, or STDs, you learn to get rid of those misconceptions and those feelings.

In the words of Erich Fromm (1956):

> If I have developed the capacity for love, then I can not help but love my brothers [and sisters]. In brotherly [and sisterly] love there is the experience of union with all men [and women], of human at-onement. If I perceive in another person mainly the surface, I perceive mainly the differences, that which separates us. If I penetrate to the core, I perceive our identity, the fact of our brotherhood [and sisterhood] (p.47).

However, sometimes students remained stuck in their anger or their judgments of patients and are unable to get past that in order to establish a connection with the patient. One nursing student tells this story:

> She was so immensely large. I'd swear she was four feet eleven inches and weighed five hundred pounds. I've never seen anyone so *huge* in my whole entire life. She could hardly walk. She couldn't climb onto the bed. She couldn't lay down because there was too much weight on her diaphragm and she couldn't catch her breath. It took three of us just to get her up from a laying position. I've just never seen anyone *that large*. You knew that all of her health problems were due to her weight and yet it was hard to feel sorry for her because it has to be self-induced. She just sits and eats and eats and weighs more and more. It was hard to feel sorry for her.

This same nursing student described her frustration and inability to establish a connection with patients when the patients were non-compliant with their medical

regime. At this point in time she espouses the notion that the patient is there to cooperate with the medical care team. For Fromm, the brotherly [add sisterly] love is described as "responsibility, care, respect and knowledge of another human being, the wish to further his [or her] life" (p.46). In other words, caring and brotherly/sisterly love are quite similar. This wish to "further another's life" does not impart the power to do so. In fact, respect for the other suggests allowing the other to retain control of his life and medical treatment. When the nurse, or nursing student, makes it her/his responsibility to force a patient to comply she/he is acting in the interest of the physician, the institution, or perhaps her/his own judgments of right and wrong, but she/he is not preserving the patients right to choose. This is an example of when 'to care' and 'to cure' lock horns. As stated earlier, according to Carol Montegomery, the only agenda of a caring relationship is to maintain the relationship between caregiver and patient. The agenda of the medical care institution is to cure the disease. Care is more concerned with the person, cure is more concerned with the disease (Geary & Hawkins, 1991).

Nursing Student Characteristics which Impede a Caring Connection with Patients

Finally, connecting with patients takes stamina. Unfortunately, about two-thirds of the nursing students I interviewed worked while they were in nursing school. Mostly they were employed as nursing assistants. Some of these students worked as much as thirty-six hours per week. One (green thumb) student pointed the finger at himself for not being able to establish connections with patients due to his tiredness. He stated:

> A lot of days I would be in the clinical setting and then immediately after that I would work a PM shift. Especially this year, I would work every Thursday the day shift as a student nurse and then I would work 3:30 to midnight and have to be back at the hospital at 7:00. With a twenty

minute ride home and a twenty minute ride back, I would average four to five hours sleep and I felt I was not what I should have been on occasion.

His point is certainly worth emphasizing. Caring relationships require energy and stamina to initiate and maintain. Energy and health are two of the precursors to the ability to contribute to a caring relationship (Diers, 1986; Peplau, 1969). Student nurses who are working too much simply will not have the stamina to create and sustain such a phenomenon. And yet, many students do have families and must work to support them and at least partially cover the costs of attending nursing school. Further, student nurses who have personal issues that stand to debilitate their capacity to care such as alcoholism, drug abuse and emotional crisis will be ill prepared to meet the needs of others. These student nurses should be identified and encouraged to seek counseling and help for their personal problems.

Insecurity, or inability to communicate, poses a problem for students in their ability to establish connections with their patients. One student couldn't really come up with a description of a caring moment or a time when he really connected with a patient. He responded by saying... "Sometimes I don't know what to say. Sometimes, I don't say much." He felt his "shyness" [translation: insecurity] has made it difficult for him to establish connections with patients. Other students expressed some shyness and some insecurity in their relationships with patients. More will be said about that in the next section.

In summary, the apparent circumstances for not being able to establish a connection with patients are; patient characteristics including anger, and unwillingness to communicate; and student characteristics including tiredness and shyness or insecurity. Students have reported feeling manipulated by patients and have expressed how that affects their ability to establish rapport with those patients. And, students have also

prevented any rapport by not accepting patients for who they are, or by making negative judgments.

Students who have described instances of not being able to connect with patients often do describe the feeling as frustrating, or as "going through the motions." In the end, students will feel that they are not putting forth as much energy for patients with whom they cannot connect. Some students appeared to become intimidated easily and "backed off after that." This backing-off leads me to the discussion of some of the variables that seemed to be present in students who did not express green thumb caring qualities.

Students Who did not Express Green Thumb Caring Qualities

Two themes stand out among students who did not express caring to the extent that some of their peers expressed caring. The first is insecurity of either a personal nature or insecurity about their competence as a nurse. The second is a focus on technical or clinical aspects of nursing somewhat to the exclusion of concern for the well-being of the patient.

Insecurity

As I stated earlier, the ability to presence self is essential for a caring connection. As a precursor to presencing self, the student must be comfortable with his, or her, self. A piece of this comfort with self has to do with the technical nursing abilities. During nursing school students are learning the necessary concepts for clinical practice and they are learning many nursing procedures; essentially the know-that and the know-how described in chapter two (Benner, 1984). Not grasping the concepts and the facts will lead to discomfort answering patients questions about their treatments, rationale, or disease process. Not being able to perform in the clinical setting will also cause a great deal of discomfort. Kleehammer, Hart, and Kleck (1990) and Kushnir (1986) have

reported the anxiety-producing nature of the clinical experience. One related article by Parkes (1985) addresses insecurity as a precursor to higher levels of anxiety in the clinical setting.

Recognizing their need to learn the procedures, students in this study unanimously stated that they wanted more opportunities to practice their skills on patients and they called for more "meaningful" clinical time in which they would have opportunities to perform a greater variety of skills. Repeatedly they stated that the simulations on mannequins and computers just were not sufficient to overcome their fear of graduating without the necessary skills to make them "competent on the floor." Without exception the students felt the clinical experience should be lengthened. This mirrors the findings of clinical inadequacy of new graduates by Kramer (1974) and Field, Gallman, Nicholson and Dreher, (1984).

The concern about skill development or opportunity to "do skills" is a concern about professional competence. A number of students stated their nervousness about starting their first job and not having attempted some of the skills. What further underscores the students' desire to perform skills is their preoccupation that nursing is synonymous with doing the procedures. When asked, "what stands out as a significant learning experience?" all of the students responded with being able to perform some skill. Most frequently cited was being able to start an IV. One student described the concern about his lack of experience with some skills in this manner:

> We can do a lot of things to a mannequin, but for all the things we learned in skills class, very few of them have been done (as I leave school now) to a live human being. I've done very few injections. I have yet to do my first IV. There is so much we cover, and I think when you start nursing school you've got this idealistic idea that by the time we leave school we

will have the opportunity to become real proficient in all these things - all these hands on things. And, that's not the case.

Unfortunately, not all of the students actively seek out opportunities to start IVs or put in catheters or give shots (Williams, 1993). The easiest way to develop skills is to take complex patients who require multiple procedures (skills). Often these patients are located in the intensive care unit and are not accessible to nursing students. However, when they are out on the medical or surgical floors these patients are intimidating to the more insecure students. The students who are most insecure will often choose the less complex patients who do not need dressing changes, catheters, IV's, and intramuscular injections. It should also be pointed out that students who have patients with no invasive procedures may request to perform such a procedure on another patient. The more confident students will aggressively seek out these experiences. When students complete their senior year and have not done a number of "skills" over the past four semesters of clinical practice on real live hospital or home care patients it is often because they have avoided, or at least not sought, the opportunity. Then, as the program is nearing completion, these same students who have felt too "nervous" to take challenging patients feel even more nervous upon graduation that they have not been "given the opportunity to practice their skills on the patients." Their nervousness now has to do with the fear that they will be alone in hospital practice and will not remember from the skills lab how to do a procedure. They fear they have missed opportunities that cannot be recaptured.

In reality, once in practice, new nurse graduates will experience an orientation phase in which they will be given opportunity to develop or refine their "skills" under the direction and mentorship of a preceptor. In addition, at any time in practice one nurse may ask for the advice or assistance of another more experienced nurse. What senior nursing students perhaps do not realize is that their perception and nervousness is

practically universal among new graduates (Kleehammer, Hart, & Kleck, 1990). Patricia Benner (1984) states new nursing graduates are at the advanced beginner stage of developing nursing competence. An individual at the advanced beginner stage is "one who can demonstrate marginally acceptable performance" (p.22). However, if the nursing student has not been exposed to a situation or has never performed a skill, he or she would be considered a novice. A novice according to Benner is one who "has no experience of the situations in which he or she is expected to perform" (p.20).

The underlying problem is insecurity. Insecurity is responsible for the lack of experience with skills; and lack of experience will lead to further insecurity. Students elaborate on the level of their insecurity in the following statements:

- "Some of the real technical things, I just can't make them make sense to me."

- "My skills are a little shaky. On mornings each day you don't know what you will do that day. It can be nerve wracking."

- "We were supposed to do some patient teaching. But I didn't know what to teach at that point."

- "I was hoping I would feel more confident to answer people's questions, but I don't yet."

- "I worry a lot. [About what?] I worry that my care that I give them will help them."

- "I don't have a lot of self-confidence that I'm doing everything the way it should be done and because of that I'm probably more focused on getting it right than on the patient. I hope that changes as I feel more confident."

- "I'm scared to graduate and actually be on my own and know we'll be totally responsible for patients. As a student you can say, 'Well, I'm just a student. I don't really know'."

- "I guess the hardest thing for me, I'm a relatively shy person and it's hard for me to do patient teaching when families are around. And, it's scary to get in there and do teaching when you don't know what you're doing or what to say."

- "I don't really know how to describe myself. I guess right now I'm kinda scared of nursing."

- "It's harder with forty year olds and fifty year olds, I'm not used to dealing with them. I like working with younger people -- you know like children."

One student reported that sometimes she was so nervous while taking care of patients that she just hoped to "get through the day." Some students did not describe themselves as shy, yet by all appearances they seemed quite shy, or insecure. They did not establish, or maintain, eye contact during the interview, they were reserved in their responses and sometimes had no response. And, while it is very awkward to talk about something as intangible as insecurity, I certainly sensed insecurity on the parts of some

students. In two cases, the students actually stated their insecurity and in three cases the students described themselves as "shy" which, taken with other variables such as the inability to maintain eye contact, I took to mean insecurity.

As stated earlier, during the interview I asked people to list every patient they could remember over the past two years. Then I asked them to put a mark by the patients with whom they were able to "connect." It was interesting to me that some students could remember fifteen or more patients and have marks by ten or more of them. Other students could not remember more than five or six and could only mark one or two.

Sometimes these students who presented themselves as somewhat shy or insecure tended to speak of memorable interactions with patients as times when they "felt good," or "had a good day." In those instances, the clinical day was depicted as "we really got along well," or "she really made me feel comfortable." In other words, the interaction was based on making the student feel comfortable rather on what the student nurse could do to make the patient more comfortable.

It was also interesting that when describing some "memorable experience with a patient" some students described an experience in which their sole part was to observe. For instance, students described getting to see a surgery, or watching another nurse do a procedure, or going on a home visit with another nurse and observing her talking with a patient.

The recognition that some students seemed insecure in their ability to relate with patients is not a criticism of the students or their participation in the nursing program. Moreover, it is simply a recognition that development and experience play an important role in student's abilities to extend themselves in a caring posture. How is development related to the ability to experience and express caring for others?

Several developmental theories speak to what Inkeles (1966) referred to as the "self system" (self-identity, self-esteem, and self-definition). Before 1968, "personality

development" theories were sparse, and the predominate presumption was that personality had already taken shape by the time of late adolescence. This is no longer the presumption (Pascarella & Terenzini, 1991).

Erikson (1959, 1963, 1968) has exerted considerable influence on most psychosocial theories of college student development. The first is the principal that "anything that grows has a ground plan, and that out of this ground plan the parts arise, each having its time of special ascendancy, until all parts have arisen to form a functioning whole" (1968, p.92). The second influential element of Erikson's work is the concept of "crisis" at given stages of development (1963). A crisis refers to a time when there are choices between alternative modes of action. The individuals choice at each crisis stage determines developmental progression, regression, or stasis. College students of traditional age are in the "intimacy verses isolation" crisis (stage five). Because caring is an intersubjective and reciprocal relatedness with another person, an "I - thou" experience, the caregiver should have resolved the issues related to the ability to relate with persons to be present in an intimate way with another individual. In contrast, the individual who has not resolved this crisis and is unsure of him/herself and will experience insecurity in interpersonal relationships.

Chickering (1969) describes seven vectors of student development during the college years. Vector two refers to "managing emotions" where "the task is to develop increasing capacity for passion and commitment accompanied by increasing capacity to implement passion and commitment through intelligent behavior" (p.53). Vector four addresses establishment of identity. This concept of identity remains a "solid sense of self" (p.80) that may undergo change over time. Vector five addresses the ability to interact with others with increased tolerance of differences and a "shift in the quality of one's relationships" (p94). These particular vectors in Chickering's stages of college student development speak to either ability to engage in one's work (passion and

commitment), to develop a solid sense of self and self-confidence, and an increasing ability to interact with others. For nursing students, caring for patients requires passion and commitment to the well-being of the patient, self-confidence, and the ability to interact with others in a caring and responsive manner.

Perhaps the most germane developmental theory which directly, rather than indirectly, addresses the ability to engage in caring relationships is that developed by Carol Gilligan (1982) in her book In a Different Voice: Psychological Theory and Women's Development. Gilligan identified a three step sequence in the development of an ethic of care:

1. An initial focus on caring for the self in order to ensure survival which is followed by a transitional phase in which persons consider their judgment to be selfish.

2. A new understanding of the concept of responsibility for others, and a period of caring for others, until awareness of the problems that arise when caring for others to the detriment of self causes a second transition period. One reconsiders relationships in an effort to sort out the confusion between self sacrifice and care.

3. This stage focuses on the dynamics of relationships and dissipates the tension between selfishness and responsibility through a new understanding of the interconnection between self and other (p.74).

If students are in stage one of the development of caring, they will have a focus on self, rather than a focus on other. If Gilligan is correct that the self is organized and

developed in relationships where the goal is increasing development of mutually empathetic [caring] relationships, then "not being able to connect" and finding no mutuality is to be anticipated among younger women and men. Mutuality or intersubjective caring may not be possible without sufficient life experience, self-knowledge, and some broader understandings of human nature and the human experience.

However, for students in stage two there will be a focus on others, perhaps to the exclusion of caring for self. This pattern for nursing students will only be known over time, when they are in work situations where their interactions with patients are more than episodic and occasional. It is entirely possible that some of the students, who do become emotionally attached and focus on the patient(s) will find that they need balance. Without finding balance they may find that they care too much for the patient and do not take care of themselves.

A common theme among developmentalists Erikson (1963), Chickering (1969), and Gilligan (1982) is: (1) the emergence of self-understanding and awareness, (2) an appreciation for the obligations to other people in one's life, and (3) a progression toward self-definition and integration. In addition, common to all of the developmental theories is the notion that developmental movement originates in the challenge to the current state of development. According to Pascarella and Terenzini (1991) "the capacity for detachment from self and for empathy controls access to higher developmental levels" (p.18-19).

This section reviewed the role of insecurity in the diminished ability to express interpersonal care in relationships with patients. The developmental theories of Erikson (1963), Chickering (1969) and Gilligan (1982) speak to the evolving capacity to engage in caring relationships for young adults. I had stated earlier that the majority of students I identified as having a green thumb were significantly older than average (over 28 years old). There may be some basis in developmental theories for this finding.

It appears that insecurity is reflected in the inability to seek challenging clinical experiences, and also in the inability to articulate a caring interaction with a patient. The implications of insecurity for nurse educators is to foster an increase in student confidence. Methods for increasing student awareness and self-confidence will be addressed in chapter five.

Focus on Concepts, Pathophysiology and Technology

A less prominent finding and a minor theme among students who did not express green thumb characteristics is an emphasis on technology, or procedures somewhat to the exclusion of a personal focus on the patient. Recall that characteristics found in the transcripts of green thumb care-givers include reverence for the patient, becoming personally involved, describing hopeful possibility for a patient, and describing an event which is reciprocal and intersubjective in nature. A few students were attracted to the technical aspects of nursing and did not discuss the more interpersonal caring aspects. These nursing students described care in instrumental terms and not in expressive terms. For example some students stated an eagerness to "get into intensive care nursing." One student was even clear that his motivation is to avoid the more expressive aspects of nursing. He said:

> I think maybe I'm interested in ICU because it's an area where I wouldn't be so affected to show care, but that the competence is more important. Even though I do care and I do show it, but I'm sort of shielded in the ICU from expressing it.

For this particular student the concepts, the pathophysiology, the technology and the opportunity to perfect his clinical abilities as a technician and a diagnostician were the most important and interesting aspects of nursing. To his credit, he is also personable and describes himself as "easy to get along with." He did not lack confidence and was

looking forward to being in practice. He related that he likes to make a contribution to patients and typically what that meant for him was coming up with some solution.

Another student who was significantly older than average described herself as one who enjoys the clinical challenge and who has an "enormous curiosity." Throughout her transcript she, too, enjoyed solving problems and "telling patients their options." When she was asked what the origin of her caring was, she responded by saying, "Wanting to come to a resolution to how we can help this patient." She described most of her patient interactions in terms of the information she was giving them.

What is different is that these student nurses speak more in terms of 'doing to,' or 'telling' and less in terms of 'being with' or 'sharing.' What is fundamentally missing is the sense of reciprocity. Clearly the students were imparting something (knowledge, skills, information and so on) but what did they receive in the interaction? Was the nature of the interaction mutual? Watson (1985, 1988, 1988b, 1988c), Leininger (1985), Boykin and Schoenhofer (1990) and many others describe the intersubjective and reciprocal nature of a caring moment. The care these two students described was instrumental and emphasized more the knowing-that and knowing-how aspect of nursing. I could not perceive from their descriptions that the interactions were reciprocal and intersubjective.

Interestingly, students who were uncomfortable with expressions of emotion did not describe caring moments with patients. These students often expressed a desire to go into nursing positions which were more technical in nature; for example intensive care, emergency room and anesthesia. For a considerable time it has been noticed that nurses who work in intensive care are more procedurally and technically oriented and are not as expressive of care as other nurses (Cooper, 1993). This observation has been made about men who are theoretically less emotional and less expressive of care than many women

(Davis-Martin, 1984; Egeland & Brown, 1989). I will discuss in greater detail my findings for the men that I interviewed in another section.

The question arises, which is the antecedent to the other? In other words, does working in a high intensity area produce less emotionally expressive nurses, or do less expressive nurses tend to choose high intensity areas? In my small sample it appeared that less expressive nurses often did desire to work in intensive care, emergency room or anesthesiology.

Knowing - Caring: What is the Relationship?

Nursing students report the time consuming and demanding aspects of learning the concepts and the skills required of nurses. A tremendous knowledge base must be learned by the students and this knowledge base is growing all the time. Students are ever aware that there are protocols to be adhered to and that mastery of concepts and skills must occur within a specific time frame and according to established criteria. Deviations from these expectations will result in dismissal from the program. And, yet for many students, nursing represents a life goal to "give back" something in this world. This kind of pressure was expressed by one student who said:

> I just felt a complete sense of being overwhelmed. In our junior year, when I was in Med-Surg., I felt that it was a ton of information being thrown at us and it was like we heard it, and we took a test on it and we forgot it all, and like it didn't really stick. We had so much material to cover at one time. I guess I don't feel quite that way now as a senior, I guess I finally got used to the pace.

> Another student was expressing her anxiety when she said:
> After the first day I was so overwhelmed. I remember just shaking, driving back to town. I was shaking and ready to cry because it was so stressful that first semester. Most of the other classmates said the same thing. It was just incredibly stressful.

The faculty and administration are bound by expanding definitions of nursing competence and increased knowledge required by the licensing boards. They must require great volumes of knowledge be attained. The question becomes: How do nurse educators humanize the process such that it is not so anxiety producing?

All of the students interviewed were asked what the relationship of knowledge to caring is. It was abundantly clear from their answers that knowledge is foundational to caring. Two types of knowledge were expressed as essential for caring for others; the first is knowledge of the self, the second is knowledge of the concepts, procedures, diagnosis, medications and so forth. The volume of this conceptual and procedural knowledge is quite extensive and "knowing what one is doing" is broadly interpreted as caring by many students. Students were aware that instrumental care was expected by patients and nursing instructors, however, expressive care provided the "feel" of being an adequate caregiver.

Another way in which knowledge impacts caring is that not knowing was a significant block to establishing rapport with patients because of students' lacking self-confidence. Students reported in a variety of ways that when they were not sure what they were doing or what they should know they had difficulty relating comfortably with the patients.

Additionally, self-awareness was stated as necessary in order to be able to therapeutically use self. Some students said essentially, "You can't use yourself to help

another if you don't know who you are." Further, one student stated, "when you have life experiences you understand better what others might be experiencing."

> There's a struggle between caring and knowing because of your own life's experiences. When you've had sorrowful life experiences, you can know the patient might be fearful and he'll tell you about it but in covering it up. Then you know the patient's laughter might be nervous laughter. Knowing the withdrawal is fear and anxiety and knowing what pain the family must be going through. It's all fear, it's sadness, and despair and happiness and joy. All of those things are wrapped up. If you've experienced those things you'll be influenced in how you care.

In addition, students were clear that conceptual and procedural knowledge alone would not make a nurse care. There must be the desire and the ability to assume a caring posture. Several students told stories of 'bad nursing' or 'bad nurses' they had observed who were "just mechanical" and not personable. In some cases, these nurses were thought to be quite knowledgeable. These examples of knowledge without care make the point that knowledge alone is not enough to foster caring in professional nurses. There are other essential components of care.

Interestingly, some students described caring as a precursor to learning. For instance, "If you don't care you won't be as motivated to learn." Carl Rogers (1979) said essentially the same thing in Freedom to Learn For the 80's. One student expressed the interaction of caring and knowing as, "If I care about something, or someone, it seems as if I really learn it better, I get more involved in it [the concepts]." Putting caring as a component of learning is an interesting finding. Belenky, Clinchy, Goldberger, and Tarule (1986) validate a way of understanding that emphasizes the importance of relationships, connections, feelings, and compassion:

> Connected knowers begin with an interest in other people's lives, but they gradually shift the focus to other people's ways of thinking.....Connected knowers learn through empathy. She [or he] learns through the lens of another person (p. 115).

Benner (1984), in an investigation of skill development in nursing, found that caring was an integral part of the development of skills and problem solving abilities. Without caring, know-how was hindered. She found that some of the most difficult problems to solve required perceptual ability as well as conceptual reasoning. Caring contributed to the nurses' perceptual ability. Perceptual ability requires a level of engagement and attentiveness which allows the nurses to perceive subtle changes in the patient's condition before any objective criteria are known. Benner and Wrubel (1989) argue that caring fuses thought, feeling, and action.

The vast majority of students saw a clear connection between knowledge and being able to effectively care for patients. Several students were able to take the distinction another step when they identified the two kinds of knowing essential for effective nursing care; knowing the self, and knowing the concepts and procedures required of nurses. Two students stated that caring was an integral part of their learning, or acquisition of knowledge; thus stressing the importance of connected learning, or personalized learning. Two students saw caring and knowing as interconnected but couldn't describe how.

Benefits of Caring

In my view, caring and codependency do not belong in the same sentence. There has been much written about the propensity of nurses to become codependent (Herrick,

1992; Yates & McDaniel, 1994). And while balance is necessary and caring for self is an important part of caring, I believe to confuse caring with codependency is another way to devalue caring in our society and to misrepresent the power of caring. Further, because caring and feminine are practically synonymous in this culture, to call caring codependency is also to pathologize women. Some nurse leaders have suggested that "the codependency label is the latest attempt to pathologize the caring professions...Society has lost the distinction between addiction and commitment" (Mallison, 1990). Rosalie and Paul Caffrey (1994) make the distinction that "caring promotes mutual empowerment of all participants while codependent caring disempowers" (p.12). However, they do go on to state that "nursing is placed within bureaucratic/patriarchal organizations which are founded on a value system which fosters codependency" (p.13).

This debate notwithstanding, the students were very clear of the benefits of caring in their budding professional practices. They believed caring provided job satisfaction and mitigated against "burn-out" for nurses. This observation of student nurses is consistent with the findings of Benner and Wrubel (1989) and Montgomery (1993). Tronto (1993) states:

> Those who care do understand correctly the value of what they do. Care is difficult work, but it is the work that sustains life. That caregivers value care is neither false consciousness nor romantic but a proper reflection of value in human life (p.117).

Students in this study believed that caring helped the patients have a more satisfying experience at the hospital and promoted better mental health and faster healing. There is more and more scientific evidence that suggests a link between "feeling cared

for" and the physiological healing process (Locke & Colligan, 1986; Pelletier & Herzing, 1989; Rossi, 1986). Achterberg (1990) explains the link in the following statement:

> The aspects of healing associated with caring -- hope, love, joy, expectation - are being documented as ingredients in the remission of disease. Second, negative forces such as loss of hope or love and the failure to adequately cope with stress have been identified as factors in both the onset and exacerbation of the symptoms of major illness. Even a decade ago, research was sketchy on these points. Now it extends through all fields of science and behavior In short, the lack of caring or nurturing may be a primary causative factor in disease, and the "carers" are involved in directly facilitating cure (pp. 192-193).

Caring was viewed as the element in nursing that served to help the patient while creating job satisfaction for nurses. It will be interesting to follow these student nurses into their professional practice to discover if, in fact, they can achieve balance in their care practices and include self-care as an essential component of caring.

A Word About the Male Nursing Students

Three of the five men I interviewed expressed what I termed "green-thumb" caring qualities. This ratio is even higher than the women interviewed. It appeared the reason men entered nursing is because nursing provides an opportunity to express care. This poses an interesting dilemma for men. In as much as caring is said to be central to nursing (Benner & Wrubel, 1988), caring is also central to our definitions of femininity in the same way aggression is thought to be central to masculinity (Edwards, 1984).

Men in nursing fit an androgenous model in that they generally are not less masculine than other males and they have more effectively integrated their female side (anima). Generally, men in nursing are a synthesis of both maleness and femaleness (Arkkelin & O'Connor, 1992). The personality profile of male nursing students is more similar to that of female nursing students than to the profiles of male college students or to the profiles of female college students. Both male and female nursing students have a more "feminine" profile than did male and female non-nursing students, yet men had a "masculine" profile similar to the general population (Davis-Martin, 1984). In other words, men have more traditionally "feminine" qualities and, at the same time, they are equally "masculine" as their male peers.

Men strongly disagree that nursing is a profession for women only. Currently about six percent of new nurse graduates are men. In a recent study of twenty-five men in nursing, most felt there were no negatives about being a male nurse although many voiced concern over general problems with nursing (Cyr, 1992). Ninety percent of men in nursing would recommend it as a profession to other men and would choose it again (Davis-Martin, 1984).

One of the men I interviewed stated:

> There aren't a lot of men in nursing right now, and maybe the ones that are going into nursing [pause]... maybe that's why that is. Because they do care. Sometimes men are more caring and I think women sometimes go into nursing because it's more traditional and more expected. But men go into nursing because they really care.

Typically, obstetrics is an area in which male nursing students feel uncomfortable (Egeland & Brown, 1984) However, in my sample, three of the five men expressed some enthusiasm for their obstetrical experience. One male student stated:

> She was a young girl and I asked if I could follow her through the birth process. At first I was kinda uncomfortable with the male-female thing, but when she said, 'That's no big deal,' I really felt comfortable. I went along to all the doctor visits with her and she called me if she had any questions and I answered them for her. Then when she went into labor she allowed me to do a lot of the nursing things that, I mean, some of the females don't even get to do. [referring to cervical assessment of labor progress] ...We just kinda grew into a trusting relationship.

When asked if there was a difference in the ways men care and women care, four of the male students answered "no," or that "there shouldn't be a difference in caring." One man stated that being a man gave him an advantage in taking care of male patients because he could "relate about things like fishing and hunting."

Some of the most compelling stories of care were taken from interviews of men. In particular I was impressed by the man who referred to nursing as his "calling." This perspective gives his involvement with patients a spiritual connotation. Further, he identified himself as a "mercy-giving type of person" for whom nursing was the best opportunity to express his concern and care for people. Because his greatest love is working with children it is his hope to eventually go into pediatric nursing. He stood out among his male peers in his interest in a maternal-child area. The remaining men I interviewed were interested in other more technical areas.

One male student stated that, although he cared for patients, he wanted to work in the ICU where he could be "shielded from expressing it." This is consistent with the literature which suggests that men move into nursing areas that are more technological and acute to reduce the role strain (Davis-Martin, 1984; Egeland & Brown, 1989).

The one striking difference in the interviews of men as compared to the women I interviewed was the degree of future aspiration or ambition. All of the male students planned to go into the ICU, or the emergency room, anesthesia, or administration. Even the man who was most unlike the male nursing profile and chose pediatrics as his favored area wanted to pursue administration "after a few years on the floor." Typically the men I interviewed saw their first job as a step ladder to something else - usually administration or anesthesia. This finding is consistent with the findings of Perkins, Bennet and Dorman (1993).

Summary

In summary, I discovered that there was a range of expressiveness about interactions between students and patients. Students who were capable of describing, or re-experiencing caring in the context of either describing a patient interaction or describing their own feelings regarding a patient I said had a "green thumb for caring." These students constituted roughly eight of the eighteen students interviewed. The remaining students were not as descriptive of caring occasions. However, these were not distinct categories of "expressive of care" and "not-expressive of care" but rather the ability to elaborate and express caring moments falls on a continuum in which some students were highly expressive and others were not at all expressive of care and the remaining students fell somewhere in-between. The dominate themes among "green thumb" nursing students, just under half the group, were a) reverence for the patient, b) willingness to become personally involved with the patient(s), ability to c) make a difference through their commitment to the well-being of the patient and by d) maintaining a hopeful possibility. In addition, for these students there was reciprocity in the relationship(s) they described with patients.

It was from the "green thumb" caregivers that I was best able to understand the nature of a caring moment for nursing students. And, it was from the students who were less expressive of care that I frequently discovered less confidence in their knowledge base and in their personal strengths. It was these students who gave me much to think about in terms of reconceptualizing nursing education such that it empowers students to come to a better understanding of themselves and develop a greater sense of confidence.

Indeed, knowledge of both a personal nature and a professional nature was seen to be foundational to the ability to presence self and express professional caring in nursing practice. Further, caring was seen to provide enormous benefits for both the caregiver and the one being cared for.

Following is a condensed summary of the key characteristics between the two groups of students; the green-thumb care-givers and the students who did not express caring to the same degree:

Table III.

Student Nurses with Green Thumb Characteristics:

Altruistic Motives
Personal Life Experience
Self Awareness
Self Assessment
v
Applies Self in Caring Ways
Focus on the Patient
Experiences is Characterized by:
Reverence for the Patient
Hopeful Possibility
Personal Involvement
Personal Learning
and Reciprocity
v
Experience is Satisfying
Affirms Choice to Become a Nurse

Table IV.

Students Who Were Not Said to Have a "Green Thumb" for Caring

Altruistic Motives
Insecurity About Ability to Therapeutically Use Self
Focus on Self, Technology, or Concepts
Able to Describe Care, but not in the Context of an Interaction Between Themselves and a Patient
Experience is Either Not Memorable, or Produces Anxiety

The next chapter will address what nurse educators can do to more effectively empower students in both types of knowing, the knowledge of self, and the knowledge of concepts and procedures. In addition, making care a more central theme in the curriculum will be addressed. Students, through the course of the interviews, did volunteer opinions about, or suggestions for, the nursing program. These suggestions will be addressed, in concert with implications from the literature, in the following chapter.

CHAPTER FIVE

IMPLICATIONS FOR NURSE EDUCATORS

"As the Twig is Bent, so Grows the Tree."

Introduction

In review, students said that not only knowledge of the concepts but also knowledge of themselves is very important to being able to extend themselves in a caring relationship. In addition, lack of self-esteem and self-confidence hampered the students abilities to demonstrate expressive forms of care in concert with instrumental forms of care. The question for nursing educators becomes: How do we encourage self-awareness and self-confidence in our teaching practices? Essentially, more reflective teaching in nursing education which emphasizes humanistic approaches, and promotes caring through empowerment, experiential learning, and modeling care will move students toward more self-confidence, self-expression and self-awareness.

As indicated by the responses of students in this study, caring may be natural but being able to establish caring relationships in the professional role is not an automatic way of relating to people. According to Roach (1984), caring responsivity remains dormant if it is not affirmed and actualized. Unanimously, students agreed that they and their peers were caring individuals at the start and that they did not think caring was a "thing that could be taught." However students did suggest that caring could be enhanced by experiencing care, by observing caring behaviors ("faculty modeling") and by "doing some personal evaluation and introspection." For faculty this presents a paradox. Caring can be learned but it cannot be taught.

Curricular Implications for Caring

Bevis (1989, p.74-77) discussed the nursing curriculum as having four curriculums. The first is the 'legitimate curriculum' which has been sanctioned and approved by the accrediting agencies and has behavioral objectives and evaluation criteria. The second is the 'illegitimate curriculum.' It consists of the values of nursing, caring compassion, politics in health care settings, and ethical dilemmas in health care. This curriculum is important, however it resists behavioral descriptors and objectives which can be evaluated. Bevis refers to the third curriculum as the 'hidden curriculum.' Eisner (1985) calls this the "implicit curriculum." The hidden curriculum is made of the messages given the students by the way we teach, the priorities we set, the methods we use, and the way we interact with students. Bevis calls this the "curriculum of subtle socialization, of teaching initiates how to think and feel like nurses." Finally, the fourth curriculum is described as the 'null curriculum.' Eisner (1985, p. 97-99) describes the null curriculum as the curriculum that is believed in by all the teachers but does not exist. Examples of the null curriculum would be critical thinking, liberal arts, humanities, creativity in the classroom, assertiveness training for nursing students and more. The reasons for the non-existence of such a curriculum are usually laid out in terms of time constraints and lack of funds.

There is debate over how much caring should be incorporated into the legitimate curriculum as a philosophical and substantive content issue. Bevis and Watson (1989) call for caring as essential content in nursing curricula. This view is shared by Bauer (1990) Leininger (1981, 1984, 1985, 1990) Symanski (1990) and Watson (1985, 1988, 1988b), who call for course work on caring that includes philosophical teachings of Mayeroff and Noddings, religious writings, and writings of nurse theorists on caring.

Caring curricula also include research on caring and the scope of the nurse caring role (Bauer, 1990).

However, students express that caring is something that can be enhanced and not taught. Further, students unanimously state that caring is a pre-existing entity and "could not be taught to someone who wasn't already caring to start." In addition, the nursing curriculum is constrained by time and generally viewed as extremely difficult for its content. I do not see adding additional coursework as a solution to the care objective. Integration is the key. The implications of this study call for a more reflective and concerted effort to demonstrate care toward students -- essentially, to expand the hidden curriculum. This would give students some direct experience with caring while in nursing school. Further, teachers could incorporate opportunities to reflect on caring practices, personal lived experiences and "nursing situations" (Boykin & Schoenhofer, 1991). In the words of Montgomery (1993):

> The vast majority of caregivers do not need moralistic prodding to be more caring. They simply need permission to have these feelings and guidance to use these feelings more effectively. Therefore, the first way to promote the learning of caring is to create the space for human feeling to emerge, and to suspend the need to suppress, control, and regulate this process (p.129).

This "hidden curriculum" could be made more explicit by placement into the mission statement, or department philosophy. Nursing students at the University of Mary, during the sophomore year, are required to read the University of Mary Mission Statement and the Division of Nursing Philosophy statement and then to create their own philosophy of nursing. This establishes the underpinning philosophies of the division and the university. It also gives students the opportunity to reflect on the philosophies and

establish or affirm their own values and philosophy of nursing. The Division of Nursing philosophy has adopted the Benedictine tradition of "hospitality" and translated it to mean "openness of heart" and "receiving others as Christ." A few students did see this as a foundation of caring. One student stated:

> "In some of the classes they [faculty] stress values and maybe the institution has values and those values are carried over and are reflected in the nursing program."

"Openness of heart" and "receive others as Christ" get at the same essential values of caring for others. Perhaps the University of Mary Division of Nursing has emphasized caring adequately in its philosophy. An interesting finding was that students who demonstrated and expressed caring relationships with some of their patients also felt that the philosophy of caring was emphasized in the curriculum adequately, whereas students who were not expressive of care did not feel that the philosophy of care was adequately stressed in the curriculum. Those students who did not feel confident in their ability to express care wanted more emphasis on care in the curriculum.

Educational Philosophy and Caring

The discipline one teaches in shapes the individual teacher's philosophy in conscious and unconscious ways. Each discipline has its own set of "isms" that define the core culture within which the teacher operates. In many cases, the teacher is unaware of the dominant teaching philosophy and may adopt it as the singular option that exists. In this manner, the teacher teaches in rote fashion, simply copying her/his predecessors without any conscious reflection. This is an unfortunate circumstance that results in some of the "stuckness" of education as we know it today.

Nursing has been predominately shaped by behaviorism. Nursing curricula are designed around; a plan, objectives, objective driven selection of materials, content,

instructional procedures, and examinations. Evaluation is based on how students achieve a preconceived, specific, measurable, behaviorally defined objectives (Bevis & Watson, 1989). It is important to note that since nursing is a practice discipline, it needs behaviorism to help nurses perfect skills. However, as recent as the middle 1980's, many nurse educators have stated that nursing is also a humanistic science (Benner, 1990; Boykin & Schoenhofer, 1990; Leininger, 1984; Munhal, 1992; Watson, 1985, 1988 & 1989). Enter humanism in nursing education.

Humanism is a broad based philosophical perspective which defies definition. However, humanistic education is broadly seen as a self-actualizing process wherein the whole person is encouraged to grow intellectually, emotionally, and socially to be able to deal effectively with life now and in the future (Power, 1990). Humanism's educational character is drawn mainly from psychologists Abraham Maslow, Carl Rogers, and Jerome Bruner; and educational philosophers John Dewey, Paulo Freire, Malcolm Knowles and Maxine Greene (Learn, 1990; Power, 1982).

Malcolm Knowles developed the concept of andragogy (1973), which is the art of adult education. In recent years, just under half of the nursing majors are older than traditional aged students. The model of andragogy as the predominate educational philosophy is most relevant for these students. Andragogy rests upon four assumptions about adult learners:

1. As learners mature they become more independent, self-directing, and will respond more favorably to mutual decision making between students and teacher.

2. The adult learner prefers teaching-learning strategies that use and value previously acquired experience.

3. The adult's readiness to learn is often oriented to developmental tasks, which generally involve perception of social role.

4. Adult learners prefer immediate application of principles learned. Adults prefer trying out creative solutions to a problem soon after the problem has been identified or posed.

Knowles' work has focused on adult learning in the Western democracies. Freire (1974), in contrast, has focused on adult learning in third world countries and has sought, through education, to emancipate regional peoples from oppression. Carl Rogers (1979) and Maxine Greene (1988) also see education as having a liberating influence on not only adults, but persons of all ages. Maxine Greene (1988) in The Dialectic of Freedom writes:

> It is through and by means of education, many of us believe, that individuals can be provoked to reach beyond themselves in their intersubjective space. It is through and by means of an education that they may become empowered to think about what they are doing, to become mindful, to share meanings, to conceptualize, to make varied sense of their lived worlds. It is through education that preferences may be released, languages learned, intelligences developed, perspectives opened, possibilities disclosed (p.12).

In Freedom to Learn For the 80's, Rogers (1979) posits that the stimulation of students' interests is dependent on a climate of trust between teacher and student, a participatory mode of classroom instruction and results in the development of confidence and self-esteem in students. These variables, he claims will be present when the teacher

exemplifies a "person centered way of being" and demonstrates "genuineness," " prizing the learner," "empathic understanding," "fundamental trust in the human being," and "a willingness to live with some uncertainty" (Chapters 6 & 7). These views are in stark contrast to the notion that learning must be painful and unpleasant and the teacher must maintain a superior status.

Dewey (1925), who has been described as an educational pragmatist, shaped humanism in education with his student focus and his emphasis on combining the technical skill, or know-how, with the theoretical knowledge, or knowing-that. With pragmatism, the experiences the student brings to college are acknowledged and constitute a starting place for learning to begin. The student is seen as capable of growth and as a participant in the learning process. In humanistic education, the teacher is also a learner. According to Knowles (1973), Freire (1974), Rogers (1979), Greene, (1988; 1967) and Dewey (1925), the teacher's role can best be described as facilitator of learning.

Humanism places great importance on caring action geared to human ideals and quality of life. Therefore caring as a behavior expressed toward students is a humanistic endeavor. Studies have suggested such behaviors expressed toward students by nursing teachers have had positive results on students outcomes, in particular self-confidence, self-worth and self-esteem (Hallsdorsdottir, 1990; Hedin, 1989; Hokanson-Hawks, 1992; Kelly, 1992; Miller, Haber & Byrne, 1990).

Green Thumb Teaching

While there are green thumb caring qualities that help patients do better and feel better there are also green thumb teaching qualities that help students develop confidence in their professional caregiving and relationships with patients. Fundamentally, the similarity between green thumb caregivers and teachers is caring for the patient/student.

Green thumb teachers seek to make a difference in their students' lives by maintaining hopeful possibilities, and maintaining a commitment to the students' learning and personal growth. Green thumb teachers engage in mutual learning and reciprocal relationships with students characterized by trust and openness. Green thumb teachers attempt to provide "experiential learning" in which caring is the natural outcome. Finally, green thumb teachers seek to empower students, encourage self-knowledge, personal growth, and self-confidence. The following sections will provide greater detail about green thumb teaching.

Student Self-Confidence and the Capacity to Express Care

I have previously reported that over one third of the participants in this study expressed insecurity and lacked self-confidence. Other nurse researchers have reported similar findings and found faculty to be an influential factor in the promotion of self-confidence or the destruction of self-confidence in nursing students. Kelly (1992) found that many of the nursing students in her sample lacked self-confidence and that faculty were influential in the presence or the lack of self-esteem and self-confidence. This finding is in concert with the findings of Hallsdorsdottir (1990) Miller (1984) and Miller, Haber, and Byrne (1990). Among the students I interviewed, student's perceptions of their most influential forces were nursing faculty, and family and friends. The faculty qualities considered to be major influences were "being supportive," taking pride in their work, "taking the time," and being involved with patients.

Confidence has been referred to by Bandura (1982) as a self-efficacy belief. Self-efficacy theory maintains that psychological and behavioral change occurs as a result of change in two types of expectations. These expectations are: (1) confidence in one's ability to perform certain behaviors and (2) an estimate of the probable consequences of those behaviors. Further, Bandura's (1977, 1982) theory posits that self percepts of

confidence are based on four sources of information (in order of descending impact): performance/task attainment, vicarious experience/modeling, verbal persuasion/praise, and emotional arousal (e.g. stress, which can undermine self-efficacy).

The findings in this study showed a corollary between lacking self-confidence and inability to express caring moments with patients, there is reason to believe that by improving self-confidence students will feel more comfortable in a care-giving role. Some of the faculty interventions that will be discussed relate directly to Bandura's model of self-efficacy belief. For example, he found that task attainment increased self-efficacy (self-confidence). The implication of this finding is that students be given ample opportunity to perform tasks and procedures in the clinical setting so they may experience success with multiple procedures. Secondly, Bandura found modeling to be an important contributor to student's sense of self-efficacy. Thirdly, Bandura describes the value of praise and reduction of anxiety as promoters of self-efficacy. In the following section related to improving the self-confidence of students, I will address empowering students, increasing and improving clinical time, reflection as a component of developing competence, and modeling care as the experiential basis of learning care. Finally, particular instructional methods are suggested for improving student self-confidence, and increasing the ability of students to establish and engage in caring relationships with their patients.

Student Empowerment

Empowering students is one way to approach students in a caring and confidence-building fashion. Empowerment in teaching is built on the feminist belief that successful and effective teaching is a co-intentional process, emerging from meaningful connections between students and faculty (Belenky, Clinchy, Goldberger and Tarule, 1988). Hokanson-Hawks (1992) states that empowerment is based on "sharing power" and is

defined as "providing the resources, tools and environment to develop, build and increase the ability and effectiveness of others to set and reach goals of individual and social ends" (p.609). Empowerment results from teaching characterized by caring, commitment, dialogue and the recognition of the humanity of both the teacher and the students.

Noddings (1984) contends that the aim of any educational enterprise is to empower the students entrusted to it. What this contention means for the discipline of nursing is that the purpose of the educational process should be to enable students to become compassionate (caring), assertive, self-directed, creative, responsive and intellectually independent. Carlson-Catalano (1988) and Glen (1990) assert that providing a learning environment that empowers students toward excellence in professional practice is the responsibility of nurse educators in baccalaureate degree programs.

Chickering offers two hypotheses related to types of teaching experiences. The first type, hypothesis A is related to disempowering students while hypothesis B is related to empowering students:

> Hypothesis A states: "When few electives are offered, when books and print are the sole objects of study, when teaching is by lecture, when evaluation is frequent and competitive, ability to memorize is fostered. Sense of competence, freeing of interpersonal relationships, and development of autonomy, identity and purpose are not" (p.148).

> Conversely, hypothesis B states that, "When choice and flexibility are offered, when direct experiences are called for, when teaching is by discussion, and when evaluation involves frequent communication concerning the substance of behavior and performance, the ability to analyze and synthesize is fostered, as are sense of competence, freeing of

interpersonal relationships, and development of autonomy, identity, and purpose" (p.148).

Empowering students to discover themselves more fully, to find their strengths and to effectively use their strengths should be the goal of nurse educators. Some of the behaviors students have reported as empowering have included respect, "not feeling rushed" by a faculty member, and supportive behaviors (Beck, 1991). Beck urges faculty members to take time with students. Support was described by Chally (1992) as endorsement, backing, approval and legitimacy. Teachers give support to students in a variety of ways; a smile, positive and thorough feedback on papers, acknowledgment of frustration, revising due dates because of sick children or deadlines in other classes, or discussing an assigned reading on a one to one basis.

In concert with Beck (1991), students in this study reported feeling supported by teachers who explained particular concepts to them privately, who allowed them to discuss their personal concerns and who did not rush through procedures in clinicals. Generally, instructors who expressed confidence in the students helped students to gain confidence in themselves.

Clinical Time

Unanimously, students called for more clinical time and more meaningful clinical assignments. Which broadly translated meant times when they could practice their skills, problem solving abilities and abilities to relate interpersonally. In concordance with the findings of Harvey and Vaughn (1990) the students in this study found the clinical experience more relevant and personally meaningful than lecture time.

In the clinical area there is a "process-as-content" curriculum (Wooley & Costello, 1988), where what is evaluated is the student's ability to carry out the nursing process

according to objectives of the nursing program. Through experience, students will learn nursing practice by applying the content in actual situations and even through making mistakes, they begin to practice skillfully. The progress of this evolving expertise has been explicated by Particia Benner (1984) in her book From Novice to Expert.

Experience is the best teacher, therefore, nursing students need better access to patients. For this to happen there must be better collaboration between nursing service and nursing education. Education and service must work together to expand clinical opportunities available to students. Clinical opportunities in the hospital setting are becoming increasingly rare. This is especially true for children and young and middle aged adults who are more often treated on an outpatient basis or discharged early. Wooley and Costello (1988) state that we need to expand our definitions of health care and of appropriate clinical settings to include the places where children and young adults can be found. Examples they give are schools, day care centers, centers for persons with developmental disabilities, clinics, Health Maintenance Organizations, and homes.

There must also be more attention paid to the adequacy of clinical sites in terms of their usefulness and the quality of the experiences they provide students (Lindeman, 1989). Concurrently, there must be greater attention paid to clinical teaching methods (Bevis, 1989b; Morgan, 1991; Wooley and Costello, 1988). Tanner and Lindeman (1987) concluded "there is little known about the effectiveness of approaches to clinical teaching in terms of student learning." McCabe (1985) points out that while nurse educators are in agreement about the importance of clinical learning experiences, there is very little research to support the effectiveness of specific teaching behaviors for the clinical setting. One particular exception in the literature was a study by Barbara Hedin (1989) on the qualities of expert clinical teaching. She found that expert clinical teachers were characterized by a deep respect for students as human beings. This was reflected in, among other things, an effort to deal with the students at their level of understanding.

This included behaviors such as taking students aside to correct or criticize them; showing sensitivity when correcting mistakes; and relating to them with an awareness of their learning needs and knowledge base.

Another study by Morgan (1991) found that the clinical area is looked upon as a rich learning environment, rather than a rich teaching environment. Several students in Morgan's study reported that a great deal of learning happened in the absence of the clinical instructor. Nurse educators have grappled with the difficulties of adequate clinical teaching (Morgan, 1991). Some nurse educators have argued for scholar clinicians as the "best" clinical supervisor (Bevis, 1989b; Kramer, Plifron & Organek, 1986). Knowing and doing is a dynamic relationship and it has been argued that the persons best able to teach in the clinical setting have stayed current with the evolving technology and complex processes by virtue of working as staff nurses on a regular basis. Kramer, Plifron, and Organek (1986) studied one-hundred -thirty-four baccalaureate students and fourteen faculty. Their work confirmed that students who worked with faculty who were also engaged in practice scored higher in autonomy, self-concept, self-esteem, locus of control, and professional role behavior than did students that lacked access to such faculty.

In essence, students have stated that they feel they need more opportunity to practice the processes involved in providing nursing care. Following are some of their comments regarding the value of clinical time:

- I just think the practice in clinicals is the most important and, I think, you just get better as time goes on.

♦ You can learn things in class and you can learn by reading, but you don't really understand it until you see it. And you don't really know your skills until you actually do them on a real person.

♦ Some of the things that really stand out the most happened in clinicals. You sit in class for two years and read the books and all of a sudden you get to start applying what you've read and it all starts clicking together.

♦ I strongly believe that the clinical time is the most important aspect because that is where you use your skills, you practice your techniques, and you communicate with the patient. I personally don't think we get enough clinical practice. Sometimes when I'm in class I think "I'm just sitting here in a classroom for two hours when I could be on the clinical floor."

♦ I like clinicals best. I feel like if I see it I'll remember it forever and we can discuss it three times in class and if I can't picture it then it doesn't stick.

♦ I've always been a pretty good student, I find clinicals very challenging but that's where I've found out that I've learned the most. Clinicals are definitely more challenging than the academics.

♦ We'd go to class and you'd hear the lectures on this and it was all fine and you could understand it but then when you went into the clinicals you could say, "Oh yeah! That really makes sense."

♦ I like the combination of clinicals and class. I like to be able to take what I've learned in the classroom and apply it in a clinical setting. It [clinicals] brings it [knowledge] to life for me.

♦ I like clinicals better because it's more 'hands on.' I learn better from hands on learning than I do from reading a book.

♦ The academic part is really vital to clinicals, but I wish there could be more clinical verses academic lecture time. More 'hands on' and actual experiences will stick with you better.

♦ I have learned a lot more from working with different types of diseases and I retained more than if I had just read it in a book.

Students who feel the need to have more clinical experience than is available through the regular curriculum should be offered enhanced clinical opportunities, perhaps in specialized areas of their interest. These internships, or preceptorships, could be offered during the summer or winter breaks for college credit. Many students work as nursing assistants while in nursing school, and while this is helpful in giving the student some experience in relating with patients it is missing the educational, or reflective component. Also nursing assistants do not usually have opportunities to "do skills" that are part of the role and responsibility of the registered nurse.

Reflection as a Part of the Clinical Experience

In addition to opportunities to engage in experiential learning in adequate environments with expert faculty clinicians, students should be given ample opportunity to reflect on the experience(s) they have had. Reflection is a process of reviewing one's clinical experience and knowledge by asking the question "What is the kind of knowledge and thinking used by competent practitioners?" The answer lies in bridging the dichotomy of "hard" science knowledge with "soft" science artistry or intuition. Donald Schon (1983) argued that both hard science and soft science are essential for professionals. Schon (1983, 1987) argued that university curricula and practice together were not sufficient to create professional competency, but that reflection is a necessary compliment to experiences. Reflection allows the novice to have what Schon calls a refective conversation with the situation. Reflecting on the unique and unexpected aspects of the case, the student frames new questions and new strategies. In addition to the added insight reflection brings to a given situation, reflection also allows the students to evaluate their own actions. One student in my sample drove home wondering, "Was there anything I missed?" [in caring for a man who had developed a temperature]. Saylor (1990) recommends the use of the journal and reflective conversations with peers and students in a "safe environment." These reflective sessions should be an opportunity to think about their work and share their perceptions and concerns without fear of judgment (p.10). Reflection should be an integral part of nursing education and professional practice. "Reflection is the artistry of combining a professional repertoire with current clinical problems to invent unique responses to unique situations" (Saylor, 1990, p.11). One student commented on the absence of reflection as part of her clinical experience when she said:

> In our clinical rotations, we're on the floor and we give care but we never discuss what we do. And I know that in other disciplines, where they have

> clinical rotations, like med students and pharmaceutical students, they get quizzed on their presumptions and they make rounds and say "This patient has this disease, so why are you doing this or that, and what other interventions should you be doing?" And we don't do any of that in our clinical practice. We're there and we do quote "paper work" and writing up care plans and stuff, but we never sit down and have like a conference time where we actually discuss the different patients and treatments.

Reflection is particularly relevant for experienced adult learners who prefer applied knowledge and integrating personal experience with theoretical knowledge. However, younger students, too, need to begin to make connections between textbook learning and the particular nuances of unique situations. In order to engage in this reflective dialogue the teacher must establish rapport and trust with the students. If the teacher is able to establish a relationship that works, it will be much easier to dialogue with students. Nonetheless, it will be much easier to dialogue with some people than with others. For some, talking and reflecting are integral to who they are. For others, finding the words and doing more than just remembering is an effort. In addition, there are differences in people, be they social, attitudinal, or cultural, which can create barriers to reflective dialogue. I acknowledge these, but believe that if the relationship is given time to develop, then there will still be positive mutual learning and slowly people will be willing to risk "opening up" in reflective dialogue. The journal offers a solution, in the beginning, for students who do not wish to share their experiences in a group.

The Need for Faculty Reflection on Teaching.

In addition, teachers, both in the clinical setting and in the classroom setting, should become reflective practitioners. Barbara Hedin's (1989) study of expert clinical

teachers revealed that one of the qualities that made clinical teachers stand out is their reflectiveness on their clinical and teaching practice. The constant engagement in self-appraisal helped them to continuously revise and improve their approaches to clinical situations. The question these expert clinical teachers often asked was: How could I have been more effective with him/her?

Other questions recommended for faculty reflection include:

> Are the teaching practices used congruent with the goals you hope to achieve?
>
> What facilitates your teaching?
>
> What is stopping you from teaching as you would prefer?
>
> What does the nature of nursing demand of the education process of its practitioners?
>
> (Hedin, 1989, p.86)

Knowing one's philosophy of education would be one responsibility of a nursing instructor attempting to improve her/his teaching abilities. Humanism has been discussed as one caring educational philosophy, however there are other educational philosophies that can be administered with care. Perhaps the most salient point is for the nurse educator to understand her/his philosophy and its place in her/his teaching.

Further, reflecting on the processes and interactions that were helpful to the nurse educator when in nursing school allows teachers to think in more conscious ways about the types of assignments they give and the kinds of interactions they have with students. Having thought about what was meaningful in their own nursing education and how

specific interactions by teachers affected them as students helps to define their teaching practices and their relationships with the students they teach. According to Hedin (1989) one nursing instructor said:

> When I went into teaching I wanted to make sure students [got positive feedback]. When I was an undergraduate student, I felt that all week all I heard was negative things. When I graduated from nursing school I had a bad feeling about myself. I wanted to make sure they felt like they were doing a good job (p.83).

Nelms (1990) found that students appreciated faculty who were open enough to share their own memories, especially their insecurities and failings as a nursing student. Students responded to such teacher self disclosure with, "Wow, if she's this smart now, then there's hope for me!" (p.293). Acknowledging their own failings as a nursing student, faculty inspire a sense of camaraderie, a sense of "if I could do it then so can you." It also connotes that the student and the teacher are sharing in a common phenomenon. This phenomenon could be fear, or insecurity, or some form of failure. The fact that the teacher can become vulnerable with the student gives the student hopeful possibility for themselves.

Modeling Care: Nursing Educators Walking the Talk

Students look to faculty to role model caring, not only in the clinical setting but in all areas of the learning context. Modeling care is defined by Noddings (1984) as "the enactment of behaviors that show oneself to another as one caring" (p.178). As Nelms, Jones, and Gray (1993, p.18) put it, "faculty should be ever mindful of the students' gaze upon us and strive to be authentic models of caring for our students." Studies within nursing education literature have documented the effectiveness and value placed on role modeling as a teaching-learning method by both nursing faculty and students (Brown,

1981; Dotan, Krulik, Bergman, Eckerling, & Shatzman, 1986; Hedin, 1989; Rauen,1974; Steubbe, 1980).

The primary method by which students are socialized to normative values and attitudes is through their interaction with faculty (Hughes, 1992). This socialization process is characterized by an ambiance that implicitly communicates those academic or professional norms and values that are of importance (Pence, 1983). This is also known as the "hidden curriculum" described by Bevis (1989) in earlier sections.

Nelms et al. (1993) found that students gain knowledge about caring through experiencing both caring and non-caring. Students in the Nelms' et al. study expressed that caring was related to them as often in its absence as its presence. Hallsdosdottir (1990) found that the caring teacher's professional competence, genuine interest, positive personality and professional commitment resulted in the following positive student responses: a sense of acceptance and self-worth, motivation to grow and achieve, and long-term gratitude and respect. The uncaring teacher's were described as having a lack of professional competence, lack of concern, demand for authority, and inhumaneness resulted in the following negative student responses: discouragement, resentment, fear, negative self-image, despair and long-term negative memories.

Cohen (1993) posits that caring must be experienced to be known. Bush (1988) identified concepts that constitute a model of the caring teacher in nursing: (a) knowledge and love of self and others, (b) presence, (c) mutual respect, (d) sensitivity, (e) communication with the other, and (f) organization of the teaching-learning situation. Students in the study of Miller, Haber, and Byrne (1990) perceived that an essential element of a caring interaction with faculty is the faculty's holistic concern for the student, personally and academically. Students identify caring teachers as being non-judgmental, respectful, patient, available, dependable, flexible, supportive, open, warm, and genuine. Hughes (1992) found in her study of faculty-student interaction that "faculty

presence emerged as dominate" (p.63). Hughes defined presence as "behaviors that convey a readiness to make oneself available to another and to generously invest oneself in another" (p.65).

Students in this study were not asked to describe faculty, or address faculty behaviors. Yet, some students were so impressed, or so personally affected by the caring modeled by some of the faculty that they volunteered praise of faculty who had modeled caring for them. Students concur that faculty presence is important and models for them caring behaviors. I have included just a few of their comments.

> "As role models, instructors show us how to be caring. I've noticed instructors that come into the room with me and they'll stand and talk with the patient as long as they have time. They're not just there to make sure I do something right and then go on. I learn from them that if they have time for patients, then we should have time also."
>
> I think when you see your teachers going out on a limb and they're helping you and they're spending this much time, and you're working with them so much. I think that they [faculty] are kind of a role model."

This student gives the implication that faculty were right at her side. Faculty establish a safety net for students and protect them from errors that could harm patients. Yet another student said of the faculty:

> I feel fortunate to have the faculty I have. They're wonderful people. What stands out is the energy that they give to the profession. The nursing faculty, virtually all of them, put what appears to be unending energy into their work and that means a lot."

Another student said:

> "One instructor in particular was so practical. She was down to earth, had good common sense and didn't try to complicate things. She tried to make [nursing] a healing and people skill with a professional concept."

Interestingly, not one student I spoke with described a negative interaction with faculty. I take this finding somewhat lightly for two reasons. First, I never asked students to speak directly about faculty. These examples where students spoke positively about faculty emerged from the dialogue about caring. Secondly, I would not expect students to confide in me any negatives about faculty without solicitation because all of the participants knew I was a faculty member on leave of absence. Nonetheless, I am encouraged by this finding.

Faculty who demonstrate caring with students are highly regarded by students. Miller, Haber, and Byrne (1990) reveal that "students perceive that caring interactions with faculty involve the mutual, simultaneous dimensions of intimacy, connectedness, trust, sharing, and respect. In such interactions, the caring teacher is one who goes beyond the expected teacher role and may be regarded as a friend" (p.129). Ron gave perhaps the most heartfelt acknowledgment of the personal involvement of the faculty with him during the time of his father's deterioration and ultimate death during the program:

> Probably the relationships I've had with the school and the faculty will stand out ten years from now. The University of Mary is unique. It's small. I feel like I've gotten a wonderful education. There's a bonding that's developed with the institution. There's a bonding with the faculty. The faculty takes an interest in who we are as people. In the nursing division, personal relationships are established and people get to know one another. I think it's exceptional.

It was the faculty who gave Ron time to cope with a tragic situation and mourn his father' death. This resulted in taking clinicals six or seven weeks into the summer and following an individualized program of study for portions of his junior year when his father was in a critical state and in his senior year when his father ultimately died. That is the kind of flexibility and personal involvement that makes a tremendous difference to students.

According to Miller et al. (1990) students who have experienced a caring interaction with a teacher report that they experience "movement toward self-actualization. They express experiencing increased self-worth, self-esteem, and self-confidence." They said that caring interactions left them "feeling good, happy, courageous and proud" (p.129). Griffith and Bakanauskas (1983) compared the student-instructor relationship to the therapeutic relationship of nurse-patient. They indicate that students benefit from a relationship that provides open, honest communication based on trust and support. They also found that when nursing students are involved in such a relationship they more readily learn the essential therapeutic approaches. Professional socialization, self-actualization, self-fulfillment, and self-concept are also effected by interpersonal relationships along with the abilities of the nursing instructor to meet the students' learning needs. Caring attitudes demonstrated by a respected instructor who acknowledges students' strengths and weaknesses are significant to students' lives and learning.

These findings that the interaction of the faculty with the student makes a significant difference to the students' sense of self-efficacy, and their overall academic and emotional growth are in concert with the recent work of Alexander Astin (1993) who suggests that interactions with faculty, both in and outside the classroom, have a significant bearing on students academic success. Such findings should be disseminated to college teachers everywhere.

Modeling caring behaviors is integral to the process of developing caring professionals. The faculty cannot speak of caring and act in uncaring ways. That would be a terrible hypocrisy.

Although students reported that faculty role-modeling facilitated their abilities to care for others, it was actually from the experience of caring for others that students created their knowledge about caring and became empowered to continue to care for patients. In conclusion, green thumb qualities among nurses may be modeled, but not instructed by nurse educators.

Selected Instructional Methods to Encourage Self-Confidence and the Ability to Care in Nursing Students

This section will provide some specific suggestions for nurse educators; the "how to" regarding helping students establish rapport with patients, and helping them to understand the meanings and the lived experience of illness and caring.

Introductions

Parkes (1985) calls for improving the communication skills of nursing students. In particular she calls for modeling, role play and rehearsal in the classroom to improve students abilities to establish rapport with patients and respond in situations where patients and families are grieving. Something as simple as teaching students how to enter a room and introduce themselves can make all the difference in the students being able to establish rapport with the patient. Many times I have walked into patient rooms with senior nursing students and waited patiently for the students to introduce themselves and me and heard nothing until I broke the silence. When students first begin working in the hospital they can be shown various introductions and then asked to role play introducing themselves in a manner which is most comfortable until they feel like they can enter a

patient's room, any patient's room, and comfortably introduce themselves. This seems minor, yet the first moment establishes so much in terms of future interactions with the patient. Presence and the establishment of rapport begin with a proper and warm introduction of the student to the patient.

Sharing of Personal Stories

Much of human understanding comes from the experiences students have had in their own lives and with their patients. This personal knowledge is lived experience which serves to enlighten the listener and also validate the experience. A personal story is a written or spoken narrative based on a real experience the student has had regarding any aspect of self-revelation and patient care. Using this kind of personalized strategy represents a type of "connected teaching" that has been suggested and applauded by Belenky et al. (1986). Stories connect the experience of an event or situation with the theoretical knowledge students have learned from books and lectures. Further, because the story draws one into the situation, it becomes a personal experience, rather than an objective one. Montgomery (1993) calls for the use of students stories to teach caring. She provides a powerful example of a student story that illustrates the caring attitudes of code team members toward a family member.

> In the middle of a resuscitation the patient's daughter walked into the room. After being given the routine advice to wait outside, she said "I need to see my father die." There was a momentary pause, after which the physician told her she could come in . After a few minutes the code was discontinued and the woman's father was pronounced dead. The physician asked the woman if she would like to hold her father's hand, and when she did, her face just crumbled and everyone just stood, enfolding her in respectful silence. After a few moments, some of the nurses and other

team members touched her gently. Gradually, with sensitive timing, they left the room, one by one, finally leaving her alone to say her good-byes. The student felt that she was caught up in a different kind of energy, and she described a strong spiritual presence (p.130-131).

This story illustrates the impact caring has, not only on the family member who "needed to see her father die," but also on the student observer. In addition, it provides one model of appropriate behaviors which seek to include family members in an experience that is usually off limits.

To provide just one example of how personal stories could be incorporated into the nursing curriculum, I have chosen a topic which, in all probability, is familiar to most people. Typically, as part of pediatric content there is a lecture on "The Hospitalized Child." The essential points of this lecture are that children experience separation anxiety, are upset by the disruption of their lives caused by the illness and hospitalization and may "regress" into previous stages of development during hospitalization. Further, hospitalization is difficult for the child's parents who often feel helpless yet responsible for the health of the child. Therefore, nurses should do what they can to normalize the hospital experience for the child; should encourage parental involvement; should understand child development and expect some regression. This lecture could incorporate a personal assignment to construct a story based on a real experience when the nursing student was sick as a child, or was a parent to a child who was sick or hospitalized. The personal stories would be given some perimeters to ensure that they are sufficiently personal and evoke the full experience of the child or the parent.

In this example, the lecture provides students with the facts and concepts related to childhood hospitalization; whereas, the personal stories engage students in the meaning(s) of hospitalization, or illness, for the child and for the parent. Stories could

then be shared in groups of three and perhaps related to the larger class group by another member of one's group.

Anne Boykin and Savina Schoenhofer (1991) strongly endorse the use of story as a method of organizing and communicating nursing knowledge. Under the leadership of Boykin and Schoenhofer, Florida Atlantic University shapes its nursing curriculum around nursing situations. They claim that through the use of the story the nursing student "truly knows caring in nursing" (1991, p.21). Further, Parker (1990) encourages nurses [add nursing students] to tell their stories as empowerment for the development of a relational ethic of care.

Essentially what the story has that the case study does not have is feeling, a sense of co-participation in an experience. While the story is experiential, the case study is an objective view of the particulars in a given situation. The case study distances the learner from the experience whereas the nursing situation engages the learner in the experience. An example of such a story follows:

> One night as I listened to the change of shift report, I remember the strange feeling in the pit of my stomach when the evening nurse reviewed the lab tests on Tracy. Tracy was struggling with the everyday problems of adolescence and fighting a losing battle with leukemia. Tracy rarely had visitors. That night I called her mother and told her that Tracy needed her. When she arrived at the hospital, distance and silence prevailed. With encouragement, the mother sat close to Tracy, and I sat on the other side stroking Tracy's arm. I left the room to make rounds and came back to find Tracy's mother still sitting on the edge of the bed fighting to stay awake. I gently asked Tracy if we could lie on the bed next to her. She nodded. The three of us lay there for a period of time and then I left the room. Later, when I returned, I found Tracy wrapped in her mother's

arms. Her mother's eyes met mine as she whispered, "She's gone." And then, "Please don't take her yet."

The story continues, the result is that Tracy's mother stayed in the room for quite a long time until the nurse went in to comfort and hold the mother until, ultimately Tracy's body was removed. If this story had been communicated as a case study, it would have included the lab values, the nutritional data, the intake and output, Tracy's affect and other factual information. The students would grapple with what kinds of medical and nursing interventions to provide. They would analyze. However, presented as a "nursing situation," the students become involved as though they were the nurse, patient, or mother. They identify with the persons in the story. They are beckoned to care. The story is treated as an experience, not an intellectualization.

I am not arguing for abandoning case studies; they are useful in developing analytical abilities and critical thinking in nursing students. Analysis and critical thinking are essential for competent nurse practice. I am, however, arguing for the inclusion of nursing situations as a method for gaining a fuller understanding of the nurse's and the patient(s) experience.

Personalizing the Language of Patient Care

Much of scientific thought, including nursing, embraces a third person perspective. We tend to speak of patients as "the one with the broken ankle," and we chart "the patient voided three times this shift." This form of "objectivity" imposes a western, male model of thinking. This depersonalization is defended as a value-free form of assessing patients. Phenomenology, in contrast, has as one of its best qualities a first person perspective. A first person perspective would tend to humanize the ways we think about patients. Human beings are the subject of nursing, not their medical conditions.

Montgomery (1993) invites nurses and nurse educators to think about the ways our relationships with patients would change and how our thoughts about patients would change if we referred to people by their names. How different the phrase "Marilyn was given demerol for pain" sounds from "the patient was given demerol for pain." Merely using her name calls us to consider Marilyn as a person who was experiencing a something called pain. This approach could potentially humanize caring for patients in hospitals. Objectivity stands in the way of a caring and human approach to persons requiring health care. Montgomery (1993) suggests that nurse educators teach therapeutic perspective as opposed to objectivity (p.88).

In this study, many of the students were not able to speak in the first person about their own experiences of caring. For example, the students said, "You just get so attached," instead of "I got so attached" or "the feeling like you didn't know if you belong there" instead of "I didn't know if I belonged there." Other students also spoke in the third person when describing their emotional engagement with a patient. For example:

- "I think everybody who came in contact with him will remember him forever" instead of "I will remember him forever."

- "You just have to separate that at times. ... you really have to pull yourself together [and not show emotion] because they are looking to you to be strong" instead of "I really have to pull myself together because they are looking to me to be strong."

- "Sometimes you just feel like taking them under your wings" instead of "Sometimes I just feel like taking them under my wings."

- "You just do the best you can" instead of "I just did the best I could."

- "Just the way they respond to you..." instead of "Just the way they respond to me."

- "It's difficult to understand what they're feeling when they won't tell you [instead of me]."

- "You're not going to get along with everybody you take care of. Of course you'll care for them but maybe not as strongly as in the same heartfelt way as a patient you click or bond with." Imagine the difference if this student had spoken in the first person. She would have to own her reality which for her is that she is not going to get along with everybody and therefore will not be able to care for some in a heartfelt manner.

This third person language distances the speaker from the experience and displaces personal responsibility to some unknown party. Speaking in the third person also tends to objectify, or generalize a personal experience. By speaking in this manner, the experience is more comfortable to discuss. There is a tinge of embarrassment about saying "I will remember him forever" because it contradicts the advice students have been given not to become personally attached. It is time nurse educators acknowledge that nurses and nursing students do care, do become emotionally involved and should be encouraged to express these moments as part of a healthy human experience. Students could be encouraged to own this experience rather than distance the experience.

The language we use has other ramifications. Hiraki (1992) reveals that decontextualized empirical rational understandings serve to objectify behavior and

remove us from human experience. Instead, we should foster communication that engages us with, rather than distances us from, the personal experience of the human being for whom we are caring. Speaking of the patient in terms of his/her vulnerability instead of the problems he, or she creates for the nursing staff would be one way to engage the speaker with the patient about whom we are speaking.

Using Literature as a Resource for Human Understanding

Sometimes the best way to "get at" or understand an experience is through the use of literature. I recently observed a family nursing class at the University of North Dakota which was team taught by Susan Henly, Mavis Lande, Bridget Thompson and Elizabeth Tyree in which students were required to read two literary works. One of the readings was a selection from among some sixty or so works on the experience of illness and/or poverty within a family. The selections included a wide array of family situations. The listing included: The Broken Cord (Doris, 1989), Dibs: in Search of Self (Axline, 1964), Retarded isn't Stupid, Mom (Kaufman, 1988), Ellen, A Short Life Long Remembered (Levit, 1974), The Children of Sanchez, Autobiography of a Mexican Family (Lewis, 1961), and Ryan White: My Own Story (White, 1991). These represent just a few of the possible selections. The students were asked to choose any book which interested them from the list and present an oral book report during a discussion group.

The second reading was a choice between two novels The Kitchen God's Wife, by Amy Tan (1991), or The Joys of Motherhood by Buchi Emecheta (1979). Each revealed the first person perspective, or the actual phenomenal experience of someone outside of American mainstream culture being battered (Tan, 1991), or experiencing role strain following the birth of a child (Emecheta, 1979). Following the reading the students were asked to write a theory paper incorporating nursing theory and how it might be applied in the story and to "address ... the appreciation of the felt experiences of others and

knowledge gained through engagement with the characters in the story ..." Engagement with the characters is not simply an emotional exercise but allows the students to expand their applications of the nursing process and nursing theory to other cultures and situations which, while commonplace, are more complicated than many students have assumed.

Gelazis (1990) expands the notion of using literature in nursing education to include poems. Students in her classes hear powerful and personal poems during their clinical conferences. Ultimately her students are asked to write a poem about their experiences, or reflections during their psychiatric rotation. One of her students (Stephanie Bower) wrote "thoughts on a gelid morning" demonstrating sensitivity, insight and caring.

thoughts on a gelid morning

i see myself reflected in the car window, weary, angry with myself at the idea of failing my family. am i neglecting them because i selfishly want to do what i feel called to do? if i have failed them; then everything i have done is of no worth.

again sipping coffee, i see myself; but this time my reflection is not in the window. it appears in the faces of those around me who are also tired, worn, sick of the struggle of life. WAIT. i see something more in these faces. i behold vulnerability, and this state cradles a pride, a dignity, a respect that is striking. this is the essence of us. for withinside this openness we are able to search deep within our souls and call upon a strength much greater outside ourselves. it is in this place where we meet ourselves and our creator and question life and its purpose.

it is here, the locus of our being, where we truly begin to feel, regenerate, and restore our sight and perchance, connect with the universe. to become part of all that is, was, and will be. in each of us this place resides. once we've been there our lives are changed forever.

> perceiving ourselves and others with this restored sight, we can no longer experience others as different, but become as one; therefore, seeing our own reflection in all of man and nature. realizing this, we can no longer crush the other. this spiritual resurrection demands that we uphold ourselves and others with dignity and respect.
>
> this place dubbed vulnerability instills in us a reverence, and we are to move and breathe within this proclamation.

When we acknowledge that we, as nurses and nursing students, are engaged with persons, not conditions, then we can see new possibilities for thinking about and relating to the persons in our care as patients. These persons are mothers, daughters, sisters and wives, and they are fathers, sons, brothers and husbands. There is common folkloric wisdom many good nursing teachers promote when they admonish students to "treat each patient *as if* he/she were a family member." At some level this is true. When one realizes the interconnectedness of humans and the commonalties of human suffering, aging, health, illness and caring then one understands that we are all part of one humanity, one human family.

Summary

In this chapter I have tried to look at what students said and what their experiences have been and I asked myself how could students become more confident and more caring. Implications based on the interviews of the students in this study are for nurse educators to encourage and empower students by providing a caring climate and opportunities for learning, for reflection and for success. In as much as caring is a "heart thing" and is experienced rather than intellectualized, I have made some recommendations for understanding human experiences. Those recommendations have

been to provide personalized education which gives the students some opportunity to reflect on their own practice and their own "lived experiences" in the caring role. Insight could be shared and illuminate situations that may arise for nurses in "real" practice. These narratives allow the student to put her/himself in the situation and call for greater understanding of the whole of the experience.

Literature is yet another way to understand human experiences of caring and suffering. This is not new advice. Educators within the professions have seen the real benefits of liberal education and the humanities in producing more depth of understanding, many have joined liberal arts faculty in the call for more emphasis on a liberal arts education. Since curricular overhaul which would promote or require more liberal arts courses will be slow to come, if it comes at all, there are methods of integrating the humanities into the humanistic teaching of nursing through the use of nursing situations (Boykin & Shoenhofer, 1991) and literature.

Finally, this sample suggests a need to expand clinical options and create more opportunities to perform procedures. This is consistent with the notion of many in education who propose that all genuine learning is active, not passive (Astin, 1993; Boyer, 1989). In addition, students have highlighted the importance of faculty modeling caring behaviors both to themselves and to patients.

> [Becomming a confident life-long learner] develops best, so far as we now know, in a growth promoting, facilitative relationship with a person."
>
> (C. Rogers, 1979, p.134)

CHAPTER SIX

RECOMMENDATIONS FOR FURTHER RESEARCH

Research in nursing education needs to continue to focus on the study of care and ways of caring. It is encouraging that there are more doctoral dissertations are being done on the topic of care and that some journals are publishing such works, but more needs to be done. This study pointed out several areas that need more attention and research.

♦To date there is very little in the literature on nursing students, or nurses, and insecurity. Further, there is very little on confidence. In fact, I could find nothing under the terms "insecurity" by computer search in CINHAL, and I was able to uncover only two articles that related to confidence among nursing students (Copeland, 1990; Grundy, 1993). There was no research on the development of confidence, or confidence as it relates to caring for patients. I see this as a glaring gap in the literature. There should be some research on confidence as it relates to patient care.

Further, research is needed on the impacts of various educational approaches, in particular humanistic or caring approaches, on the development of confidence and caring in nursing students. Although research has been done to evaluate the effects of certain variables on self-efficacy (self-confidence), no research has been designed to examine the effects of an educational environment on self efficacy. Research is needed to determine the student-perceived climate for caring and the immediate and long-term ability of students to enact the nursing role as one of caring.

- Currently there are some nursing programs which do provide course work related to caring. It would be of great interest to nursing educators and curriculum planners to know how the students perceive these courses. Have these courses made a significant difference in the ways they think about and care for patients? In short, are courses on caring worthwhile? Such courses would necessarily replace other courses. Before educators consider such program changes there should be some research, from both faculty and student perspectives, on the value and the meaning of such courses on caring.

- Follow-up research should be done to evaluate the effectiveness and the students' perceptions of the recommended strategies for student nurses. For example, the use of personal stories, literature, expanded clinical time, emphasis on reflection, and personalizing the language of care not only in the classroom, but also in the hospital and in the patients' charts.

- Regarding this particular research on the "lived experience of caring for senior nursing students" it would be useful to get fresher perspectives when the incidents spoken about are current. Memory is a curious thing, it can either enhance or cloud an experience. And, while I accept with full credibility the stories related to me from the experiences of the students, I believe that these stories could have been more powerful, more "true to life" if they had been told within the context of "life as it happens." As time goes on, the experience becomes objectified. When it is fresher, it is personal and more vivid.

There are two possible methods to consider. The first is to become a participant observer and interview students as opportunity and situation allows about meaningful patient interactions. This could be done by clinical instructors because they are in the

best possible position to know when a student has had a meaningful clinical experience. These stories could be taped and transcribed over the course of a year or more.

The second method would involve journaling by the students when the experience is fresh. For instance, as part of every post clinical conference students could be asked to spend fifteen minutes reflecting and writing about their experiences that day including interactions with patients, feelings, experiences and learning that occured during the day. This journal entry could be incorporated into the study and events which seemed particularly relevant could be examined more fully in follow-up interviews.

- Studies of men in nursing are rare. More studies of men and caring and men in nursing should be undertaken. Since the prevailing view of men is that they are less caring than women and less expressive of care than women, it would be particularly interesting to explore the lived experience of caring for men in nursing and men in nursing school.

- Another important recommendation for future research is the phenomenological illumination of the lived experience of nursing educators. What has meaning in the lives of nursing faculty members? J. Timothy Leonard (1987) said "teachers bring their own persons to the concrete task of teaching in the specific circumstances within which they find themselves" (p.24). It would be interesting to discover what teachers make of these circumstances and their own abilities as teachers in both the caring role and the informative role. Experiences to consider for this particular study would include describing a time when the teacher was able to help, encourage, promote or inspire a nursing student and alternatively describing a time when the teacher failed to help, promote or sustain a student.

- Replications of this study should be done with participants from diverse backgrounds. Joan Tronto (1993) has suggested that those in society who are the working poor and working class are most likely to have the burden and responsibility for caregiving. Many nurses, nurses aides and licensed vocational nurses fit this description. How do persons who are over-burdened with caregiving and without adequate social and financial resources maintain caring? Again, phenomenology offers the best method by which to understand the experience from the perspective of the speaker.

- There is nothing in the literature on the development of caring from nursing school through practice; therefore, it would be important to do a follow up of the eighteen students in this study to determine if the ability to assume a caring posture increases as competence develops. According to Benner (1984) the development of competence takes about two years of full-time work in a particular area. Hence, follow-up interviews should be conducted at least annually for no less than two years.

Theoretically, as competence increases nurses should feel comfortable with procedural care and may be more "at ease" with expressive forms of care. Then in actuality interpersonal intersubjective caring should increase as competence improves. What will be the effects of high patient turn-over, poor staffing and high patient ratios on the actualization of this theory? Students, during their education, do not have exposure to these experiences. Does the ability to experience caring relationships with patients actually decline as job stress and role strain increase?

In the end, there may not be generalizeable conclusions but rather specific stories of caring. Professional nurses may experience episodic caring. If caring is found to be episodic, then understanding its ebb and flow and how nurses handle these episodes

would further illuminate professional nurse caring and the implications for nurse educators could be outlined.

Because nursing is a practice discipline involving caring and clinical competence, a "good nurse" is one who has integrated caring and practice. Research which illuminates the process of developing confident, caring nurses is research which will certainly advance the profession, not through the conventional methods of scientific quantification of data, but through understanding the nature of caring and the possibility posed by teachers and learners in the development of caring. Ultimately, patients, our mothers and fathers, sisters, brothers, sons and daughters, will experience the benefit.

POSTSCRIPT

I have been cautious about reducing the experiences of the nursing students I interviewed to categories and generalizeable conclusions. It is my hope that the categories and the metaphor of gardening serve as useful devices to make the information more cohesive and understandable. Moreover, I believe the most compelling portions of this thesis exist in the stories of the students and their perspectives. I tried not to dominate, or interfere with the students "lived experience" but rather to shed light on experiences, to reveal the association of the student's experiences with the literature and to underscore their experiences.

I began chapter four by saying how valuable this process has been for me personally and professionally. I will end by saying my teaching of nursing students will never be the same. Indeed, I have learned the value of a personal approach and have developed an even greater respect for the process of becoming a nurse. I was most deeply touched by the students' openness, their thoughtfulness and their hearts. Their stories and their lives serve as an inspiration for me and I will never forget them.

APPENDICES

APPENDIX A

LIST OF UNIVERSITY OF MARY NURSING PROGRAM DEGREE REQUIREMENTS

COURSES REQUIRED FOR A DEGREE WITH A MAJOR IN NURSING AT THE UNIVERSITY OF MARY

ENG 103	The Writing Process
COM 109	Oral Communications
*BIO 209	Microbiology
*BIO 207	Anatomy & Physiology I
*BIO 208	Anatomy & Physiology II
CHE 109	General Chemistry
*CHE 110	Intro to Organic & Biochemistry
*SOC 107	Sociology
*PSY 201	General Psychology
*PSY 206	Psychology of Human Growth & Development
*NUR 122	Introduction to CLinical Nursing
*NUR 248	Health Assessment
*NUR 202	Foundations of Nursing
*NUR 317	Basic Pharmacology
*NUR 316	Basic Nutrition
*NUR 301	Skills for Nursing Practice
*NUR 303	Nursing Care of Women and Children
*NUR 302	Concepts & Issues in Nursing
*NUR 305	Nursing Care of the Adult
*NUR 401	The Research Process
*NUR 402	Management in Nursing
*NUR 407	Complex Clinical Problems
*NUR 409	Community/Mental Health Nrusing
One	Aesthetics Course (literature, music or art course)
Three	Courses in Philosophy or Theology
	Electives, as needed, to meet graduation requirements

The following are general degree requirements at University of Mary:

1. A minimum of 128 semester hours is required for graduation.
2. At least 64 of these hours must abe earned in a 4-year college/ university (i.e., no more than 64 credits can be transferred from a junior college.)
3. At least 44 of these hours must be at the 300-400 (junior/senior) level with aminimum average grade of C.
4. At least 60 of these hours must be in the liberal arts.
5. At least 32 of these hours must be earned at the University of Mary.

* A grade of at least a C is required.
For admission into the Division a GPA of 2.5 is required.

N.B. Enrollment in NUR 301, 302, 303, 305, 401, 402, 407, and 409 is ordinarily restricted to students who have been accepted by the division of Nursing.

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APPENDIX B

INTERVIEW GUIDE

INTERVIEW GUIDE

1. How old are you?

2. What motivated you to choose nursing as a career?

3. Are you now, or have you ever worked in a nursing related capacity?

4. If I were to ask your patients to describe you to me, what would they tell me?

5. This is a more personal take on who you are: How would you describe yourself as a nurse?

6. When you look back over your junior an senior years as a nursing student what will stand out most to you?

7. Can you remember your very first day in the hospital as a junior nursing student? What was going through your mind then?

8. Some students like the academic aspects of nursing school and other students prefer the clinical portion. What can you say about clinicals or academics in nursing school?

9. Have you had a particularly poignant moment when you knew that you had really learned something well? Can you describe it?

10. What has been the hardest thing to learn?

11. What has been the most fun to learn?

12. How would you describe caring?

13. How do you think caring develops for nursing students? (explore) Is that how it has been for you?

14. What do you think the source (origin) of caring is for you?

15. Now I'd like you to make a list of patients you have had over the two years as a nursing student. I'll give you several minutes to do that.

** Circle the patients with whom you had a memorable interaction.

*** Have you had a very caring interaction with one of those patients that you could describe?

a) what was happening?

b) what were you thinking?

e) what do you imagine was happening for the patient during this caring interaction?

** What makes the patient's circled different than the patient's not circled?

** Let's go through the patients you have circled. What stands out for ....

16. Has there been a time when you got emotional in the clinical setting?

17. Have you had clinical experiences when you didn't really feel empathy, or maybe didn't connect with a patient. What was that like? Would you say that this is a common experience?

18. Do you think the ethic or philosophy of care is emphasized enough in the nursing curriculum?

19. I'd like you to complete this sentence. Some of the ways I express caring in my work are.....

20. What do you imagine to be the difference for a nurse who experiences caring interactions with patients and one who does not?

21. In your experience is there any connection between caring and knowing? Can you describe how they are connected?

22. What would you say will be your biggest challenge in the work place?

23. How can I reach you this summer to verify my summary of this interview?

24. Would you be willing to be interviewed again after you have been in practice for about a year?

APPENDIX C

CONSENT FORM

CONSENT

You are invited to participate in a study of the "lived experiences of caring and knowing in senior nursing students." We hope to come to a better understanding of the nature of your experience as a student and care-giver. If you choose to participate you will be asked to describe yourself and your experiences as a nursing student. In particular, I will be interested in those experiences in the clinical area, or in the classroom which stand out as memorable.

The interview will take approximately one and a half hours. The interview will be arranged around your schedule and you will have your choice of interview sites; the Butler Center, the University of Mary, your home or my home. I will be compensating participants with a $15.00 payment as a small thank-you for your time which I know is valuable and hard to come by in your senior year.

The interviews will be audiotaped and transcribed. All comments will be reported anonymously. I will identify participants only by a number, ie. "student 12". I will keep the code of what number belongs to what student along with the tapes and transcripts in a locked file in my own home. One year following the completion of the study the tapes will be destroyed. I will not discuss the tapes or the transcripts made from the taped interview with any nursing faculty or administrator during the time of the study. The analysis of the transcripts will occur this summer, after you have graduated. I will be contacting you by phone to further clarify the themes identified in your interview transcript.

For purposes of internal, or external, (National League of Nursing) evaluation of the nursing program, your statements may be used, but only anonymously. No statement will ever be identified by the name of the person who made it.

In the dissertation, or any publication about this study, I will refer to students as "one student reported..." or I will assign pseudonyms.

Your decision to participate will not prejudice your current, or future, relations with the University of Mary Division of Nursing. If you decide to participate, you are free to withdraw at any time without prejudice.

I am available to answer any further questions you might have concerning this study. You can reach me at 1-795-3655 (M-Th), or 222-0423 (F-Sun.).

- -

I _____ have read this document
student
and understand the terms of my participation. I, therefore, do consent to be interviewed by Sherry Neil-Urban as part of the study of "the lived experiences of caring and knowing in senior nursing students."

_____ _____
student's signature date

_____ _____
Sherry Neil-Urban (researcher) date

APPENDIX D

SAMPLE INTERVIEW

INTERVIEW 2

R: So, can you tell me how old you are?

S: I'm 31.

R: OK - good. What motivated you to choose nursing as a career.

S: I've always liked nursing, I didn't do it at first because I didn't think I was good enough or smart enough, and that I guess what really made me get into it is, is the fact that I like people and I like to help with that and care for them. take care of them.

R: Have you ever or do you now work in a nursing related capacity?

S: Nope.

R: So you've really given yourself a time to go to school, plus have your family...

S: Yeah -take care of the kids and the family...

R: There's plenty of time for work. If I asked your patients to describe you to me, what would they tell me?

S: Ahm, I think generally I genuinely care for them and care about how they feel, and that I am as gentle as I can be during the medical procedures. I like to talk to them and I like stay with them while something else is being done to them I like to come to talk to them and, you know, keep their mind off the procedure. And, I try to be honest, I think that shows through.

R: Well, there's another way to get at this, too. If you were to describe yourself as a nurse what would you say?

S: That I am giving. I don't like to rush out. I like to spend every minute of my time in talking to the patients. Getting to know them, like I said, I'm caring and compassionate and let's see...I help them out and listen to them, I like to listen and have uninterrupted conversations and give them time to express themselves.

R: OK. Good. When you look back over your Junior and Senior years as a nursing student, what will stand out most to you?

S: As far as nursing applications?

R: Ah, anything that comes to mind. If I were to say to you five years from now, "What was it like in nursing school?", what would be your first thought?

S: I liked it because I liked the work in the hospital. I liked the clinical experience. I liked that more so than the classroom, of course. But I liked getting in there and caring for the patient, and basically being their care provider for the day, and that's the, I think that's the most important part, that's the thing that I liked the most.

R: OK. OK. Can you remember your very first day at the hospital as a Junior? And, if you can...

S: *(chuckles)*

R: ...I know I'm asking you to go back, but if you can, can you remember what you were thinking that day?

S: Oh!

R: What's that?

S: I was thinking that, I know I was scared to death, I was really scared, I knew I didn't

know enough to give enough care to a patient, but you know, as you work with it, and you work with them, you kind of get into the role, and so then you relax a lot after, you know, the first hour or so.

R: Hmm, Hmm..

S: But I know, I know for the first, I was just scared to death.

R: Where were you? What area?

S: I was up, let's see what, they called it neuro..

R: Oh. Neurosurgical?

S: Hmm, Hmm. I had an elderly woman and she had had fainting spells and so then she was up in there running, being tested . And I felt sorry for her because she had me..(chuckles) because I wasn't, you know, I was just really scared. But I got over it and then the second day, when we went back, I was a lot more comfortable with it and I gave her her shower and did it faster than what I had the day before. I got more into the role, I think it was easier the second day.

R: Hmm, Hmm. That first experience of getting your feet wet... really can be scary. (pause) Um... Some students like the academic aspect of nursing school and other students prefer the clinical portion, what do you say about clinicals and academics?

S: Hmm. Like I said already, I like the clinical more than the academic part. I do, you know, I do like the academic portion but I think in my own thoughts that the clinical is more important to me, and trying to help the patients that I have I think is more important to me than reading about a different disease, I think I have learned a lot more from working with different types of diseases and I retained that more than if I

just had read it in a book.

R: Is there an area that you're more confident? Are you more confident, say, taking tests verses working with a patient or visa-versa? Do you have an area where you think you really shine more than the other?

S: In the clinicals?

R: Is that the answer - that you feel more confident in the clinicals?

S: Yeah, yeah...

R: OK

S: I do.

R: Have you had a particularly poignant moment when you knew that you really learned something.

S: Hmm, yeah. Learned something about school or...

R: Whatever comes to your mind.

S: I guess, I think what comes to my mind the most is when I was working ER and it was my first flotation through ER, I guess I was kind of nervous of, you know, because things were faster paced. So when there was an accident and it was involving a 15 year old boy and they brought him in, he wasn't doing very good, and he had chest trauma. And he ended up dying. And ah, you know, just being a part, you know, watching all the ER unit trying to work on him and then when his parents were told and stuff, I mean, I say I'll never forget, you know, the faces and their reactions and I learned a lot about dealing with the parents, family members in general with the death.

R: Well, tell me about that. What did you learn about, from that?

S: Hmm. Well, it was kind of, it was a bad situation because the driver of the car, he was 15 also and he was, there were 3 boys in the car. And the driver of the car was brought to St. A's and the passenger in the front seat probably was taken to Med Center. And then the one in the back seat was Adam, and that was the one that was the worst. He had the chest trauma and then there was no identification on them and the ambulance drivers thought he was 18. And, you know, but then, all of us in the room just didn't think that he looked 18, but, you know, anything's possible I guess, and the boy that was driving, when they brought him in, they were asking the boy who was in the car with him and he gave two names, and then they asked who was in the back seat because they knew that this boy, this "Adam"-boy was in the back seat. And he told them it was a totally different name, he said it was so-and-so. And so in the wreckage, in the computer and everything they put it down as being this boy and then when the parents came in, (they had been called) and they came in looking for their son and the woman at the desk said that he wasn't there and that he must be the one at MedCenter. She said, "No, I want to talk to somebody else." I can still picture her face. Then they called MedCenter and asked and they didn't have that boy either so then they were trying to get some identifying features of him. They didn't know what he was wearing when he left for school which is you know, typical for a 15 year old and I can see, you know, you don't really pay attention to what they're wearing. So they couldn't tell us that. They had pictures of him but they weren't real recent ones and so then, the policeman brought the pictures in and they had to try to identify him by the pictures, that I thought the eyes weren't the same, but one of the guys was, he didn't think that they were the same. So then we ended up we had to have the dad come in and identify him and he did. He came in and at first he just stood there and shook his head and didn't, he was speechless more or less, and

didn't say anything and you know, the nurse had to ask him, you know, "Is that your son?" And it ended up it was. So then, you know, that was really hard and then I learned what goes on during a trauma...

R: Hmm, hmm.

S: Yeah..*(clears throat)* And after it's not successful. And, we had to get him ready for the parents to see him. The biggest thing that I'll always remember, and I think I learned the most about is talking to his parents, because they weren't accepting it, they were in denial and they didn't really want to accept the fact that he was dead and they kept trying to get us to do more, and you know, they did everything possible...but they wanted us to keep going and bring him back...

R: That must have been hard...

S: Yeah, it was...

R: So what happened to you when all of this is going on?

S: Well, the nurses, they were very good. They asked if I wanted to talk about it or if I needed to be alone, or if I wanted I could go home. So then I wasn't comfortable, with just saying anything, these people I had only met, like an hour ago because I had only been on this shift only an hour...

R: And then to have it be such a new kind of situation, I can't imagine how you would know what to say to the parents at that time. (pause) So you were pretty upset by this? *(hushed voice)*

S: Yeah...

R: And did you end up going home?

S: No, I stayed

R: Hmm, Hmm

S: I did stay, I ahm, I wasn't feeling with it, probably even I was still in the denial part too. That and probably if I would have left to go home I would have probably ended up stopping and crying my eyes out, you know, but ahm, I just stayed and worked through it...

R: How did you work through it?

S: I talked to my husband when I got home. I also have talked to other nursing students, one that I hang out with a lot...

R: Connie brought up this case. She said that there was a situation that came in with a boy that died. She said it was really emotional for the nursing student. I didn't realize that person was you.

S: Yeah... I know it hit Connie hard, too, because she has a boy that's that age too, and so I think she's become more aware of the boy and I know I have.... I guess, I went home and went into the bedroom and just kind of stared at them to see if they were OK.

R: It's a pretty profound experience...
Do you think that sort of caring and becoming involved in patients is ah .... How can I put this? How do <u>you</u> get taken care of when you're emotionally distraught over a patient?

S: When I'm a nurse already?

R: Yeah.

S: I think if I'm a nurse, working at a place, I will have bonded with the other nurses in the area I work, you know, not just the nurses but the doctors and I think once you have the tight bond I think then you can cope with your needs, I think you can, you

know, deal with each other and help each other through things. And what I did learn is that was the way it was in ER that night. They did kind of work together and went through everything. The nurse I had, she was, she said she couldn't deal with things--when they happen, like the other one's were and that she had to deal with it by herself first and she said that I could come to her, but then again and I had just met them and I guess I didn't feel comfortable..

R: So you were able to get more comfort from your close friends and husband...

S: Yeah. That night I went home and just talked with my husband. Sometimes, between the friendship you gain from being a part of a team and the friendship that I have with my husband, I think that, it will get me through those situations.
get into a team, smaller groups, and I ended up in her group...

R: Hmm - It's good that you've got that much friendship. Sounds like your husband is a pretty nice guy, too.

S: Yeah

R: Well. Let's see. In the question that I asked about a poignant moment when you've known something well, it was a very poignant moment, no question, grief has something to do with what you learned.

S: I learned, I think, one of the things I did learn that is how grief really happens. You can see it on TV, you can see the actors, when somebody dies and the families are all upset, and you hear about it, read about it, you can see it when it's not real, but when you're in a situation and you see a real life situation like that, that's when you really learn about it. That it is real, that it's different than what it's portrayed on TV. The actors do a good job and all, but, you still know that that's not real, that it's not true and that it's just something to make a movie, but this was real. Since then, you know

in community, when we had do a self-help group so a friend of mine, another student asked me if I wanted to go to, it's called "Good Grief." It's put on by one of the instructors at MedCenter One. And, uhm so her and I, I was at St. A's hospice for my mental health and she was at MedCenter hospice, and so then she asked if I wanted to go to it and so we went to it for part of self-help. I don't know if it's a coincidence, I believe it was a little more, somebody pushed it, you know at me, and I think. But when I got there I was standing there in the room waiting for them to start and in walks Adam's mom. And, you know, I looked at her and I, I mean everything just came back and so we were sitting across the room from each other not talking or anything *(clears voice)* and then we had to number off and get into smaller groups... and I ended up in her group.

R: Why am I not surprised? (I have goose bumps.)

S: And you know, I just, it was too bazaar. So anyway, we had gone around talking about who in your life had died, you know, and different things. If you wanted to say anything, you could cry or do anything. It got to me and you see I have never had the experience of somebody close to me dying yet. And so, you know, I didn't know how anybody feels. I know, I can imagine how I will feel when like my mom dies, but I was not in that situation so I, you know you don't know. So I just said that I was there, I was a student and I really didn't have anything to say. Then after the meeting, that was when she had cried a lot in the meeting and I kinda choked back the tears. It's like people questioned about why I would be upset over this. So after the small meeting we were supposed to get up and hug each other, and everybody got up and they were hugging each other and Bonnie and I were standing there, just the two of us, nobody was available except the two of us and also it was the fact that I was left out, that I ended up in her small group and that we ended up the only two

people not having anybody to hug. And so I went over and I hugged her, and I don't know, I just started telling her that I was there and from there we kinda bonded and it was a series of six meetings, and I only had to go to one to fulfill my self-help group, but I went to all six of them and it ended last Monday. And, but anyway I was talking to her and we talked a lot about him, we cried a lot about him and I told her how I feel and she told me how she feels and on the second Monday, it was on feelings and the different feelings that we go through. Her feeling right now is the anger, and the things she was saying really opened my eyes to how angry somebody can actually be. There again you can see it on TV and read about it in our books, but you know, I guess hearing the way she....the things she wishes on the driver of the car, things she wrote down, she wrote letters and was going to send them, but she wrote letters to him and told exactly how she feels, just the anger and hatred that she has. I learned a lot about the feelings and how somebody can actually really hate somebody, and you know, when actually it was a bad situation. It was, the boy, the driver was driving reckless; he was speeding, and he was swerving in and out of traffic. But, you know, how many other kids do that and how many other adults do that? But they have not gotten caught, they have not gotten into an accident and into a situation and you know like even yourself can speed, 'cause I remember I always did that, but she doesn't understand, she just understands that he did it and he killed her son and so she is angry and there's nothing that can be said to change her anger. That's another thing I learned is because, I didn't think that it was that much anger and that much hatred inside of her.

R: **So did that scare you?**

S: In a way, yeah. Because, you know, it could have been anybody. It could be my son that died and something like that happen.

R: Let's hope it never does...

S: You know, I think, I think my kids are the best in the world, you know and to think that somebody could think bad about my kids, you know, if they were in that situation and it was my son and that somebody could actually hate my son that bad

and wish a lot of things on him. I guess in that was it was kinda good to bring out some fear.

R: So you had this sort of therapeutic relationship with Bonnie and that every week you go, and I imagine every week she says something to you because you were there and she has a person she can relate to about this. And I can imagine this brings up a lot of feelings for you. I just have to remark there's something remarkable about doing that -- about going six times when one was required and about keeping it therapeutic, you've allowed yourself to be this person's, uhm, to be their, maybe their stable rock, I don't know, but that says a lot about you.

S: We never get, you know, we talked about that she could call me, like I told her she could call me if she needs me. She wants to get to get together sometime, and go out for lunch, or have some coffee and I told her I as willing to do that and I asked her if she brought a picture of him, you were supposed to bring a picture of who, and so I brought a picture of him along with me to show you...

(she takes picture out of her wallet)

R: Oh, gosh, it just breaks my heart looking at it... I'm going to read this out loud, OK?

S: OK

R: It says, "To _X_, I wish Adam could have known you. He would have truly enjoyed your friendship. You are very warm and compassionate. Hope we can keep in touch and be friends. Adam's mom, Bonnie"

Some of these questions after what you've shared will seem really superficial. What's been the hardest thing to learn?

S: The hardest thing to learn...gosh. Other than that, I think that the hardest thing to learn is that I don't know everything, you know, I mean people ask me questions and I can't always answer them and I guess that, I mean I know I can't know everything, don't get me wrong, I don't know everything *(chuckles)* I know I don't, but I was hoping, you know I could feel more confident to answer people's questions, you know, and learning that I could... that's not even a good answer! *(chuckles)*

R: No, I understand this. If I have it right, the hardest thing is not to be able to answer to people's concerns or their needs because you don't yet know 'em enough to be able to do that. And that may be frustrating. Yeah, OK.

S: It is, it's frustrating, ahm, so that you, you know, I guess that it makes me feel that they don't see me as totally competent. If a patient or somebody asks me, you know, "What about this?", and you know, I don't want to make them think that I know it, you know because, you know, I could guess what the answer is, you know. And so I am honest and I tell them I don't know and that I'll go find out for them but then, I guess, I wonder do they still look at me as being good enough to care for them or do they look at me that I didn't know something so I shouldn't be...

R: So it's almost as if you're suggesting that not knowing puts you in a compromising position with your patients and their families that you feel somehow they may not respect you or regard you with the degree of confidence because you don't know everything yet...

S: Yeah, Yeah...*(chuckles)*

R: Yeah, something like that? Oh, I understand, I've been there - Many times! What has been the most fun to learn?

S: The most fun ....just the whole nursing package.

R: OH!

S: I love it!

R: That's so nice to hear!

S: The whole, from when I started out, you know, you take the intro to nursing class, I think that was then that you know you really are in nursing, you know.... *(chuckles)*

R: And at that point you're in your Freshman, or is it Sophomore year?

S: Freshman. I guess I like that part of school because, you know, not all degrees start you out as a Freshman. You have to take all of these classes up until you're a Junior and accepted into the program, and then you start. But I like, I liked learning that first (going into nursing) because it made you actually think that you are going into nursing and that you can do it and I just, I just like going into the hospital. I guess they make they feel like you are somebody special, the patients and the faculty.

R: How would you describe caring?

S: How would I describe it? *(looks puzzled)*

R: It is tough, I agree, it is tough.

S: How would I describe it? Being there for somebody and whether it's friends or family or even somebody you don't like. It's talking to them and listening to them a lot. Asking them how they feel, asking what they think, it's not always what we think, it's more times what they think. Ahm, it's being nice. It's being there for them when they need you.

R: Hmm, that's good. How do you think caring develops for nursing students?

S: How it develops for them? I don't know if I can say it does. I think, I think I always have been a caring person and I think that's why I'm in nursing because I have always cared about people. I've always cared about how they felt and how they react to different things and always tried to be there for people. And I guess I don't see that going into nursing made me care any more than I already had. I think maybe the way I was raised. I'm a caring friend and I guess I, if you don't have care, then I don't think you can learn to care, and I don't think that you can take a class in caring and learning the different aspects of it, I think it has to be inside you and it has to be openly given.

R: And you think that nursing is just a vehicle which you can express the caring. You wouldn't really agree that nursing provides you with any special tool in order to be able to care, it just provides the opportunity.

S: Those people that don't care, you know that don't have care, and ahm, and whether they go into nursing or not they still see that they don't have the same things. You know you can see the difference in people..

R: Hmm, Hmm...

S: ...and see how they react towards their patients, and towards the family. I know a few of my fellow students who I don't think they have a lot of care and I guess, you know, a couple of them are going into nursing for the money part of nursing and you know, they don't treat their patients with the respect that I know I have for mine....I mean I'm not saying I'm better than them, I'm not saying they're better than I am, but...

R: No, No, I understand...

S: But I, but I do see how they just go in and just do what has to be done and then come back out and see what else they can do to occupy their time. Instead of going in and taking the time with the patient and, you know, getting to know them, talking to them and ahm, you can't spend your whole time in there talking, but I think you have to show them the respect and, and take your time to show them that you care.

R: Hmm, Hmm..

S: And I think there are nurses that don't have any care and there are nurses that really show their care, and there are some that can't show their caring. They may have it, but they can't express it very long.

R: What do you think the source of caring is for you? the origin? You may have answered this; you talked about a very loving, caring family..

S: Yeah. My mom. My mom is she has always cared, she was a very caring person and just keeps caring and hasn't stopped.

R: And I guess being raised with a caring mom and...

S: My dad is too, but not as much. That's more my mom I think, and a, she's an emotional person and I think I am too. I inherited that or something. But, a, she has always cared about how people are and how they feel, and I think that's my source, I think I'm amazed....

R: She's been your model, she provided you the example, OK. The next thing I want to do and I'll shut the tape recorder off for a moment and just give you a minute to reflect on the patients you've had over the last two years....

PAUSE

R: OK. We're going to talk about just one or two of those on X's list especially since she spent quite some time about her relationship with the family of the boy who died in the ER. So, before we do this, a question comes to my mind, is there

an area in nursing that you especially like?

S: What I really wanted to go into when I first started out is NICU because I like working with babies and small children. I like the care that, I think what really draws me to that is that these babies need a lot of love and care and ah, and I thinl that's basically what draws me to it is that... I like, I like working with them. That's basically where I would like to go is ICU.

R: I wish you luck. You might not start out in ICU, but hopefully you can get there. OK. (pause - pointing to the list) Why don't you talk about the woman with the broken leg in OB?

S: Yeah.

R: OK. What was that about?

S: There was a, when I was in OB, on Monday I had a patient that she had a broken leg and she had just given birth to her little boy and, really, and in report we were talking about that the woman, I guess what stands out mostly is that she hadn't had any prenatal care up until a month before she delivered and then she went in to the doctor and she was an alcoholic and she had been drinking and she fell down the stairs and broke her leg. That was five days before she gave birth to the baby.

R: Was the baby full-term?

S: Yes.

R: OK. So what was your relationship like with this woman?

S: You know you have kinda of that, "How could you do this?" (drinking) You know

when there are so many other things that go wrong with babies, the anomolies, and you know, and fetal alcohol syndrome, and stuff. I guess when you think of all the things that the babies can go through without adding the alcohol part to it.

R: Hmm, Hmm

S: It kinda of, you know, makes you angry to think that somebody would do this while they are pregnant, but yet you can't, can't go in and judge her, you can't say, "Well, how could you do that?", you have to accept her, you have to treat her like anybody else.

R: So could you?

S. I went in there and talked to her and I asked, I said, you know, how difficult it must have been to give birth with a cast on, and we talked about that a little bit and I asked her a couple question, like how she broke her leg and she kinda joked with me about how she fell down the stairs, you know, I guess it didn't really bother her, so I didn't want to make it look like I let it bother me. So I just did her things and talked to her a little bit, I didn't really know how much into the alcohol part I should talk to her. I didn't really discuss that part with her because I was, it was last year, you're only there four hours and I wasn't sure how far I could go with the drinking. Because she never, you know, if she would have brought up the drinking part maybe I would have taken it from there and talked to her.

R: Now, do I have it right in my mind? You were having all these, kind of judgements really, but you weren't going to share them because you really know you need to accept the patient while their in your care. And you also have these patient teaching concerns but you didn't quite feel ready or able to handle them at that stage in your nursing education?

S: You know in a way I wish that I would have been able to. You know like, if you were there for longer than for the four hours maybe, I guess you have to build up a closer relationship before you can begin talking about the personal things...

R: To some degree I think that's true. Yeah, you can't walk right into her room and say, "So how much you do drink everyday? Tell me about it." I mean she'd probably..

S: I think, you know, you put people on the defensive when you just jump right in and say, did you know that this isn't good, and what you do is alienate them. I think you have to get more rounded, more into their life than just to prove that oh, she was drinking and fell down and then you go in and tell her that how bad that was and that she shouldn't have done that.

R: That's a good point. So you can't take it from the nurses report and then go with it, you need to develop the relationship with the patient first. I see what you mean.

S: I think that we spend too little of time so you can't, I didn't anyway, build up the relationship where I would feel comfortable bringing it (the drinking) up.

R: OK. Is there anybody else here that you really think, ah, that had a lasting impression on you or you've had a lasting impression on them.

S: Yeah, I had in hospice, just this last semester, I had a, he was a 41 year old man had bad lung cancer from smoking. And it had metastasized to his brain and, so I think I learned a lot from him because, ahm, of the different things that happens when one's part of the brain is taken over. He was an alcoholic also. So then they, like the nurses in hospice had a hard time regulating his medication, you know because the hospice belief is to keep him as comfortable as possible. And so he was on a lot

stronger doses and had to be changed more frequently because of his alcohol use and he had also, when he was younger, like in his 20's and stuff, and has some drug use, and so they worked a lot with him and his wife. I went in as a volunteer type of thing and sat with him for a while so that his wife could go out with the daughter, and ahm, he wasn't the typical brain tumor patient; he was a very hyper person who was always up and fidgeting with everything and trying to get everything as best he could, that he thought was the way it should be. So we had to watch him a lot. He, after awhile lost use of his right side and so then he was, but in his mind, he wasn't comprehending that he didn't have control over himself anymore. And so he would try to get up and he would try to crawl over the rail of the bed to get out of bed, and he fell a lot and bruised himself up, you know, real bad. And his wife felt really bad. She thought everybody was going to say she was...

R: Beating him up...

S: We worked real close with that family and trying to get the wife, actually it was his ex-wife, but when she found out how sick he was she took him back. The only reason they divorced is because of the alcohol. She still loved him and you could see that she loved him and the way she'd hold his hand...

R: So who were you most involved with . . . the patient or his wife?

S: His wife, mostly.

R: So what was the connection with his wife?

S: Ahm, trying to, because she still had to work, and then she was at work for 8 hours and then she'd come home and care for him for the rest of the day. There was really

no break for her and just trying, you know you'd go in and talk to her and you'd sit there and talk to her, you know, even if you just sit there with her that's about all you'd have to do, she, she-a, couldn't go out because she was caring for him. He was really dependent on her, and so just to go in and spend some time with her talking to him. I know she had questions and she'd ask me things...

R: So what was your role with her?

S: Ahm, mostly in the way of friendship. Someone to talk to, somebody who would listen to her, and not just come in and check how Dave is doing and then take off...

R: So, you didn't leave in a hurry?

S: Yeah - because, you know, they have other patients to go see. And because Dave didn't, he wasn't able to talk, really. He could slowly say one or two words but we had to really work for him to say them. So because of that there were a couple of the nurses that, would go in and say, "How's he doing; what's he doing", run in and then they were gone. I guess I felt she needed more time spend on her also.

R: You were interested in her well-being and perhaps she needed someone to talk to. Sounds like you were able to give some support.

S: Yeah, more supportive.

R: Aha, aha...

S: Talk to her and listening to her. If she had any questions, she would ask. Just to keep her sane, you know, more so because, because she was, he would keep her up

after work.

R: I can imagine that she must have been just exhausted.

S: And they lived in a little house and he slept on a hospital bed in the living room and she slept on the floor right beside the hospital bed. She had been sleeping on the floor since, for 6 months now. In fact, she just said she doesn't even know if she remembers what a real bed feels like.

R: Did you find it a moving experience.. it strikes me as interesting that she would come back to him in his hour of need with that kind of sacrifice to be with him.

S: Hmm -

R: They had obviously been through some hard times before, and she came back.

S: You could tell by the way that they looked at each other that the love was still there and they still cared for each other. Because when she went out to work one day, his mother came down to sit with him and he knocked a hole in the wall with his fist and he threw the commode across the room on a different day and then when she came home he would sit there. And, you know, he let her do anything to him. He got to where he was in Depends and he let her *(the ex-wife)* change his diaper where he would fight with the nurses when they would come in and try to do it. He wouldn't move his legs or he'd, you know, if it was up to her he'd help her along, even though he couldn't say anything. Oh, Another time he knew exactly when she went to work and what time she was supposed to be home and it got to be the time when she got off work. So then every car that drove by he was out looking at the window, to see, you know. And then he was just really agitated, and a, his mom said that Linda had

stopped by the grocery store to grab some groceries, because it had been like a half an hour that she wasn't home yet and she was really agitated and so he was just, he was not settled until she got home. And then when she got home then he was fine.

R: In light of this, you had to learn a lot... Right? As you're saying he can barely talk too, but he doesn't, he couldn't say for instance how frustrated that he was feeling... *(pause)*

Do you ever have patients that you don't really connect with or don't feel much empathy for? Do you ever feel like you're going through the motions... in nursing?

S: Hmmmm - no not really. I guess, you know it would have been very easy to that with the woman that I had in OB, but I guess because you have to put your judgement's aside and you are more or less, role models, you have to, you're still there to care for the patient and make it as best that you can. I guess, it would have been really easy to just go in and say, "Hi", check the fundies and turn around and walk out again, but I guess she doesn't benefit from that and neither do I. I guess I, if I don't get to know them then I don't really learn about them. Then I'm not doing my job.

R: Hmm - that's a good point. I hadn't thought of that.
R: Do you think the philosophy of care is emphasized enough in the nursing curriculum?

S: In our nursing curriculum? Ahm, yeah, I think so. I think when Sister Bernard firsts starts you out I think, I think, she's a real caring person, and I think it shows.

R: So you would say that it is more a matter of modeling that faculty, *some* faculty in particular have caring behavior. There's no class on caring... but it's modeling...

S: I think it's more, you know, in the modeling like you said. Ahm, we see how they are and how they are to us. There is no, uhm, we don't have a class like, "Today we're going to learn about caring," I don't, I don't remember anything like that....

R: Earlier in this interview I think you said something to the effect that you didn't think it could be taught in life, so you wouldn't even support such a class.

S: No.

R: OK. I'd like you to complete this sentence: "Some of the ways I express caring in my work are..."

S: Some of the ways.. Ahm - Listening - Helping - Helping them through a situation or helping them get to where they want to be. How I express caring....Ahm. Just by taking the time, taking time with the patient and the family, answer questions if I can. *(chuckles)*

R: Do you use much touch with patients?

S: I guess it depends on the person..

R: Aha, Aha..

S: I guess I see how the person is before I, an I idea. If it's a person that responds to touch, like Bonnie. Bonnie and I hug and we put our arms around each other and even just to hold her hand while she's talking or something. But at first at I don't think I do because I don't know if they are that type of person. I guess it could go either way.

R: You're a little cautious about it though. You don't walk in and assume that it's

O.K. to put your hand on someone's shoulder or whatever. It seems like you kind of feel it out and...

S: After I get to know them, and I'll, you know, rub their back and pat them on the back, and if we're talking, but I think at first I feel out the situation more so.

R: Correct me if I'm wrong but seems like what you were talking about in with being with patients is presencing yourself. Would that be an accurate description of what you experience with your patients?

S: Yes

R: I want to get it right, because I have to summarize this interview and I want to be accurate, and I don't want to use terms loosely.

S: OK. I think that's a good term.

R: I'll tell you what I'm getting from what you've said, Uhm, I think that you love people and you haven't said the word, "Love," but it's really in between the lines. I mean, would that be accurate?

S: Hmm, I do. I admit I do love people. I like to know them. I like to know what makes them different from everybody else.

R: Just a couple more questions and then... I think you'd be a good person to ask this question to...."What do you imagine to be the difference for a nurse who has caring relationships with patients and a nurse who doesn't." Like what's maybe the difference between you and you've mentioned even some of your peers that you think that don't really care about much.

S: You mean what do I do that makes...

R: No, I mean...

S: How the patients react...?

R: That and the job, I mean there are two ways: How do you think the patients react differently?

S: They're not as open as what they are if you care a lot, you know if you show them the care. They're more open with you, they'll tell you the way they feel. If you say, "Well, how do you feel today", and just show them that all you care about, you know , they'll say, "Fine", you know. But if you talk to them before hand and get to know them and then say, "How have you been feeling? How did you sleep?" and I think they're more apt to tell you the more personal side. The inner feelings more so than just, you know, what you want to hear.

R: Do you think the person who cares and has that kinds of relationships with patients, what do you think that does for the job satisfaction?

S: Well, I think, I think it's more satisfying, because you know, caring isn't just to get the money; I think that you go to work to talk to people and...

R: Be in relationship...

S: And I think, you know, if you do have the relationship part then going to work isn't so hard and it's not that you're going just for the money. I don't know, I think that the patients themselves benefit, too.

R: Do you think there's any connection between caring and knowing? And if so, what's the connection?

S: Caring and knowing?

R: Sounds like a trick question doesn't it? *(chuckles)* **You'll be graded on this one! No, that's not true...**

S: Ahm, I think it would be that if you know yourself then you care. If you can, If you know yourself and you know how you feel and how you react, you show more care than if you, you're still trying to feel out who you are, I think then you don't really care about who the other person is. I think you're more concerned with how *you* are than how *they* are.

R: Let me see if I understand you. You say basically you have to get some of the personal issues handled and kind of out of the way and once you're secure in your person you can relate easier or better with another. Would that be sort of a...

S: Yeah - because you have to know yourself and you have to know who you are in order to show somebody else how you care.

R: And does it have to do with that whole concept of using one's self as a therapuetic tool?

S: I think so..

R: I mean if you don't know who you are, how can you use yourself? You have to understand your strengths in order to use them?

S: I think so, because I know pretty much my strengths and weaknesses..

R: Do you think that's an advantage for you because you're older than say, a . . . some of your peers?

S: I do. I think so because I think I'm through that phase of going out just for a good time and, I'm through with getting to know yourself, I think I've pretty much, figured

out who I am and what I can do and what I can't do.

R: What do you think will be your biggest challenge in the workplace?

S: The biggest challenge...to not get calloused.

R: Do you think your . . . does that seem possible for you?

S: No..*(chuckles)*

R: No - you're so emotional.

S: I don't think so, but everybody says that nurses get calloused and pretty soon they don't care anymore and after they've worked so long they just go through the motions basically.

R: How can you prevent that from happening to you?

S: I don't know, I guess, I don't know. I don't see myself getting that way, but I want to prevent that if I can.

R: Sure, I understand that because you have a gift and you don't want to lose that.

S: And if I cry, I mean, I cry...

R: Have you had tearful times with patients? Obviously with the family in ER, I mean, other than that.

S: Yeah, but not, just not with them, really...More by myself when nobody is around.

R: More after the fact?

S: Yeah. I guess a lot of that is feeling comfortable with where I am and once I'm in the real world of work I guess, you know I guess, because you're a student, I think, you're looked at a lot and judged a lot, and I think that, you know, a lot of people who go, "Oh, look at that dumb student", you know, who she is and look at her cry. I guess I didn't feel comfortable at the time, because I guess I didn't know the other workers at the time.

R: But you can imagine if you were in a setting that you work all the time that you would probably feel more comfortable.

S: Even, even in ER when the family was in, it was like, if somebody would have talked to me I would have cried, but because I didn't know anybody, you push it down as far as you can as hard as you can, so then when I left, then it came out, you know and so I think, when I was with somebody I knew, which was my husband, then I started crying and was able to talk about it -- when I got home.

R: It's a story you'll never, ever, ever forget that day nor the relationship that you established with that mother. It's very easy to keep coming back to that... but.. You say, basically to summarize your answer about the biggest challenge would be to keep from becomming calloused or jaded. And you're so emotional and sensitive, I can understand that you want to keep that sensitivity to patients.

How can I reach you to verify this interview? (She tells me.)

R: I have another question. Would you be willing to be interviewed in about a year, after you've been in practice for a year?

S: Sure

R: I sure appreciate it. Thank you. I appreciate your time.

APPENDIX E

SAMPLE SYNTHESIS OF INTERVIEW

Synthesis - Interview #2

31 year old female

You are a very warm, caring and personable person who enjoys people, genuinely loves caring for people and has found a wonderful match between your people skills and interests and your career choice. You state whole-heartedly that you "love nursing - the whole nursing package."

Upon entering nursing school you initially lacked self confidence, you made statements such as "I didn't think I was good enough or smart enough" to be a nurse. It appears that you have gradually and consistently improved in your sense of confidence in patient care from the first day of clinicals in which you stated you were "scared to death" to a much more self assured competent nursing student -- now nurse. You describe the "getting into the role" of a nurse as something that happens as you begin to work with patients. It is a process which builds on experience. Yet you remain somewhat disheartened that you don't know everything. You describe the frustration you feel when you can't answer all of the patient's questions. You want to be totally competent at this stage, and be perceived by patients as totally competent. Yet I suspect that patient teaching is perhaps one of your strengths.

You describe yourself as gentle, caring, one who likes to spend time with patients, one who is compassionate, and enjoys really listening to patients and being there when they need you. Caring for you is a pre-existing value and way of being nursing simply provides the opportunity for you to express the caring that is inside you. You have a certain reverence for your patients and their circumstances. You are accepting of them regardless of your differences in beliefs. I am referring to the young woman who is an alcoholic who fell down the stairs when she was about nine months pregnant. You were able to be warm and accepting with her even though you had concerns about her lifestyle and the baby's health.

You have enjoyed clinical experiences more than classroom experiences. You state you like the experience of "being the patient's care provider for the day."

The story you told of the fifteen year old boy who died in the emergency room will stay fresh in my mind for quite some time. The most compelling part of that story for me is that you cared enough to develop an ongoing relationship with the grieving mother. It is quite telling that you carried this boy's picture in your wallet. It seems as if this incident affected you quite profoundly. For instance that you attended 'Good Grief' meetings with the mother, during which time you bonded with her, you related the experience to your own children and you discussed it with your husband and your close friends. This is the kind of involvement that makes nursing much more demanding than many other kinds of professions.

Because you have tended to get so involved with this patient you are somewhat concerned about your personal boundaries and recognize your ongoing need for a good support system. Currently, your husband and a few close friends are your support system.

Themes from your transcript are, initial insecurity and anxiety, supportive care, using self as a therapeutic tool, empathic understanding, self awareness, touch, explaining, listening, presencing yourself, not rushing, taking the time, genuineness, perseverance, gentleness, reverence and love.

Thank you for the interview. I learned so much from you. You exemplified caring in so many ways. Thank you . I wish you the best of luck in your nursing career.

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