The Lived Experience and Perception of Nursing Student Interpersonal Communication in Nursing Practice Rotations

by

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Abstract

The purpose of this study was to examine the perceptions and lived experiences of nursing students' interpersonal communication with clients and nurses upon completion of nursing practice rotations of undergraduate nursing education. The study identified the extent to which nursing student participants were aware of the roles, relationships, and statuses in the context of nursing practice rotations, and how this awareness shaped their interpersonal communication with clients and nurses. Ecological Systems Theory and Critical Systems Theory were used as complementary theoretical frameworks to explore the system of layers of roles and relationships and to employ a critical lens. Hermeneutic phenomenological research methodology, specifically the approach of Max van Manen (1990) was used to gain the essence of the 12 participants' lived experiences of interpersonal communication with nurses and clients on nursing practice rotations: feelings of overwhelm, unpreparedness, and powerlessness in their roles, relationships, and status in communicating with nurses and clients. The principle themes of Holding on to the Traditional Student Role (role stagnation), Learning to Become a Professional Nurse within a Community of Nurses (role transformation), and Experiencing Disempowerment as Learners (role oppression) within the ecosystem were deconstructed to make recommendations for nursing education.

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CHAPTER ONE: INTRODUCTION

Within present undergraduate nursing education scholarship, a need for communication education has been identified in all areas of nursing practice (Boschama et al., 2010; Krautscheid, 2008; McCarthy, O'Donovan, & Twomey, 2008). Historically, nursing students have learned to communicate as nurses by replicating the communication skills, attitudes, and behaviours of nurses in classrooms, labs, wards, corridors, break rooms, and cafeterias of nursing faculties and their associated nursing practice settings (Űstun, 2006). In more recent years, some nursing faculties have offered short courses in communication for nurses (Bambini, Washburn, & Perkins, 2009; Keston, 2011; McCarthy et al., 2008; Pearson & McLafferty, 2011; Ryan et al., 2010; Zavertnik, Huff, & Monro, 2010). However, the lack of standardized preparation of nursing students in communication continues to be the norm, in spite of the fact that competencies for communication are an integral part of professional licensing criteria of nurses worldwide (Lin, Chen, Chao, & Chen, 2012), including the national and provincial regulating bodies for Canadian nursing (Canadian Nurses Association [CNA], 2011; College of Registered Nurses of Manitoba [CRNM], 2009). As a consequence, nurse educators are enduring a time of trial and error in learning the means and methods to teach communication. In the nursing education context of this study (an undergraduate nursing program in a faculty of nursing), a formal communication for nurses course was absent in the curriculum; rather communication used by nurses, such as interview skills or therapeutic communication, was integrated within various Nursing courses or Nursing Practice Rotations (NPR), albeit unsystematically. The purpose of this study was to examine the perceptions and lived experiences of nursing students of their interpersonal communication with clients and nurses upon completion of their final

nursing practice rotation to better understand the ways that roles, relationships, and power in nursing practice rotations shape the students' interpersonal communication.

Key Roles and Terminology within the Study

Communication is primarily the outcome of the identity development of the nurse through the institutional, social, and technical skill demands of the nursing profession that in nursing education program culminates in the final NPR, Senior Practicum. Jürgen Habermas provides a critical theory of communication, the Theory of Communicative Action and Reason within which to frame this discussion of the development of (interpersonal) communication of nursing students. Because English translations of Habermas's *Theory of Communicative Action (TCA)* [see McCarthy, 1984, 1987] are extensive, I limited my use of TCA to Habermas's intersubjectivist approach, meaning that actors (in this case, nurses) attempt to realize their own goals through speech with an orientation towards mutual understanding of each other's meanings (Habermas, 1987). I apply Habermas's ontology, a process of rationalization that he calls *modernity* in the formation of individuals (in this instance, nursing students) in the *lifeworld*, the backdrop consisting of the structural components of social integration, cultural reproduction, and socialization of nurses (Habermas, 1987). Hence, in communicating with nurses and clients, the nursing student is orientating herself/himself towards mutual understandings of what it means to be a nurse and renegotiating a new social role as a nurse.

Habermas's typology of communication allows an assessment of the structural type and situation of action. In the *TCA* (Habermas, 1987), the most basic mutual understanding is language, that is, if two individuals do not speak the same language (in terms of vocabulary, word choice, and jargon or terminology), they will experience difficulty communicating. Both sides of the communication must have mutual understanding of the meaning of the

communication. The communication must be understood by both parties as valid for mutual understanding to occur. The three functions of Communicative Action are to: convey meaning, establish social relationships, and express one's opinion and feelings (Habermas, 1987). Each speech act aimed at mutual understanding has three claims to validity: truth (the validity claim to represent the speaker in the world), rightness (the validity claim of the speaker to establish legitimate intersubjective or psychological relations between the speaker and the other), and truthfulness (the validity claim to express the speaker's intentions) (Habermas, 1987). These validity claims to truth and rightness are tested by discourse where parties deliberate the truth of the matter with evidence and discuss the rightness of what they can expect from one another. Lastly, the claim to truthfulness is tested by comparing utterances with the subsequent actions of the speaker over time (Habermas, 1987). In sum, reality stems from interactions in that language and action are linked.

Because the teaching and learning of interpersonal communication in nursing education is a complex endeavour for both nursing students and their educators, the following concepts, roles, and norms of the nursing education program of this study must be considered: (1) interpersonal communication of nurses, (2) how the roles of the client, the nurse educators, the staff nurses, and the nursing student shape the communication, and (3) the culture of nursing practice which is also known to nurses as *the nursing practice culture* (Bartholomew, 2006).

Interpersonal Communication in Nursing

Communication is the means by which nurses enact such nursing values as the provision of safe, compassionate, competent, and ethical care; the preservation of dignity; and the maintenance of privacy and confidentiality (CNA, 2008). Nurses communicate to impart caring with clients, the interpersonal art of nursing (Bick, 2010; Watson, 2008; White, 2012), and they

participate in conversations each day with colleagues to negotiate their practice within the powerful complexities of the health care and political systems (Doss, DePascal, & Hadley, 2011; Gruber & Hartman, 2007; Leenerts & Teel, 2006). As such, effective communication promotes healing, health, and well being, not only in clients, but also among the very professionals who care for others within a challenging system of high demands and limited resources (Beckett, Gilbertson, & Greenwood, 2007).

While the importance of effective communication in nursing practice is well documented, significant variation exists as to the definition of *communication*. In the nursing literature, communication has been defined as: a process (Dreger, 2001), a developmental issue (Berglund & Saltman, 2002), an intervention and skills-based competency (Bick, 2010; Gruber & Hartman, 2007), and a means to create and sustain relationship or partnership (Hartrick, 1997; McHugh Schuster & Nykolyn, 2010). These varying definitions of communication in nursing are fundamental to our understanding of the function/purpose of communication, the context within which communication occurs in nursing practice, and the ways that power is translated into interactions between clients, nursing students, and nurse educators.

At the same time, discussion of nursing communication is also comprised of written communication (in the form of nursing students' assignments, care plans, or charting) and telecommunications (such as telephone calls, email, health records, or other forms of electronic communication) (Whittman-Price & Goodwin, 2012). These forms of communication have different attributes, all of which need to be developed and integrated by the evolving nurse and be flexible enough to vary with position, clinical context, power relations, and other aspects of setting and development. Moreover, many discussions related to communication in nursing include inter-professional communication between nurses and physicians, pharmacists,

physiotherapists, or other health care providers (Keston, 2011; Krautscheid, 2008; Thomas, Bertram, & Johnson, 2009). In contrast, I was interested in nursing students' understandings of building and sustaining relationships with clients and other nurses using communication as part of their practice.

Therefore, I reviewed the work of seminal nursing education theorists in communication (De Leeuw, Van Meijel, Grypdonck, & Kroon, 2012; Doss, DePascal, & Hadley, 2011; Hartrick Doane & Varcoe, 2007; Henderson, 2003; Leenerts & Teel, 2006; McCance, McCormack, & Dewing, 2011) to delineate nursing definitions of communication into a specific term for the purpose of this study: *interpersonal communication in nursing practice*. Interpersonal communication in this study was: (a) the behaviour of face-to-face messages, in the form of words or oral language, non-verbal/body language, and proxemics (the spatial distance between individuals) to complete a specific nursing task/goal, as well as (b) the attitudes and relationships that shape interactions and power during nursing practice. In particular, nursing students' experiences of engaging in interpersonal communication with clients and nurses was the focus of this study.

The Client Role

Individuals in the care of nurses (and nursing students) in this study shall henceforth be referred to as *clients* rather than patients to include, not only those persons who receive care from nurses within facilities (such as hospitals or personal care homes), but also those persons cared for by nurses within communities (at clinics, schools, or health promotion activities). The positionality of clients within health care must be recognized. Scholars [see Alcoff, 1988] claim that one's identity is shaped by the relational position within a context rather than by one's essential qualities or characteristics. In other words, the client's ability to voice his or her own

care needs and health concerns is largely constructed by his or her position with the nurse and within the unit, health care context, and larger society that influences the health care system.

Clients interact with nurses and other health care professionals because they necessitate care that they cannot manage independently or with the help of a family caregiver. While under the care of nurses, clients communicate with relative strangers who have intimate knowledge of their bodies, minds, and lives (Theodosius, 2008). Many of these personal acts of care and communication regarding a client's pain, toileting, hygiene, or illness often occur in public places with limited privacy which are all too commonly overcrowded, understaffed, and bound by busy schedules and routines (CNA, n.d; Watson, 2008). Clients and their families experience fear, concern, or powerlessness at the loss of health and rely on nurses to provide them with information and care (Theodosius, 2008). Among the health care team members, nurses are known to have the most direct and frequent interpersonal contact with clients (Whelan & Moralejo, 2011) who at times, express their feelings of powerlessness through aggression toward nurses (Shields & Wilkins, 2009). Given the great needs, vulnerability, and potential volatility of the client and his/her family, the nurse (including a relatively inexperienced student nurse in white scrubs) has tremendous responsibility and power over (and in relationship to) the client. Consequently, a study on interpersonal communication in nursing practice needed to employ a conceptual framework that took into account that power is present in every nurse-client encounter.

Nursing Education

Nurses practice within a system constituted of layers of relationships (Bronfenbrenner, 1979); nursing students experience these relationships as part of their education and socialization to nursing. An understanding of the embedded relationships within nursing education is

fundamental to this study of the nursing students' lived experiences of interpersonal nursing communication. In essence, the students' relationships with their nurse educators and clients prepare them for the realities of the profession (King-Jones, 2011).

The nursing student. A student is defined as a *nursing student* when he or she has been admitted to the Faculty of Nursing and begun second year courses. In this study, acceptance to the Faculty of ùnursing required that students pass (a minimum of) a preliminary year of 30 credit hours of prerequisite courses: two biology courses (Anatomy [3 credit hours] and Physiology [3]), two Nursing courses (Human Growth and Development [3] and Introduction to Nursing [3]), one microbiology course (3), six credit hours of Psychology, Sociology, or Anthropology, six credit hours from the Faculty of Science, and a three credit hour Humanities elective. Applicants also had to meet the minimum adjusted grade point average (AGPA) in the most recent 60 credit hours (Option 1) or, more commonly, in all credit hours totalling less than 60 (Option 2) (Faculty of Nursing, 2013). Entrance to Nursing was competitive; the minimum AGPA for the 2013 to 2014 regular session was 3.5 out of 4.5 for Option 1 and 3.8 out of 4.0 for Option 2 applicants (Faculty of Nursing, 2013). Only once a student had met these requirements and submitted criminal records and child abuse registry checks, was he or she admitted to the Faculty of Nursing (Faculty of Nursing, 2013). Therefore, nursing student was an achieved status based upon high academic standing, the absence of serious infractions within Canadian society, and access to the funds necessary for tuition.

Four year undergraduate nursing program. The conceptual framework for the undergraduate nursing program in this study is Health Promotion Across the Lifespan (Faculty of Nursing, 2005). This conceptual framework addressed two core concepts of nursing, the enhancement or promotion of health within the specific discipline of nursing, and the lifespan as

nurses care for individuals, groups, and communities at all stages of life (Faculty of Nursing, 2005). Nursing Practice Rotations, known more commonly among students and nurse educators as ***clinical practice*** or simply *clinical*, were inserted within each year of the curriculum as linked to the requisite coursework and skills laboratory.

Table I: Undergraduate Nursing Curriculum

Year in the Program	Faculty or Department	Course	Credit Hours
2	Statistics	Basic Statistical Analysis	3
2	Nursing	Health Assessment	4
2	Nursing	Skills Laboratory	2
2	Nursing	**Clinical Practice 1***	3
2	Nursing	**Clinical Practice 2***	3
2	Nursing	Pharmacology	3
2	Nursing	Health Promotion of Older Adults	4
2	Nursing	Health Promotion of Child Bearing and Child Rearing Families	6
2	Human Ecology	Nutrition of Health and Changing Lifestyles	3

*In second year, nursing students participate in two NPRs, one related to older adults (gerontology) and one related to child bearing and rearing (maternity-child).

Year in the Program	Faculty or Department	Course	Credit Hours
3	Nursing	Research Methods	2
3	Nursing	Skills Laboratory	2
3	Nursing	Health Restoration	6
3	Nursing	**Clinical Practice 3***	3
3	Nursing	Health Maintenance	6
3	Nursing	**Clinical Practice 4***	3
3	Nursing	Introduction to Legal and Ethical Foundations of Nursing Practice	3
3	Native Studies	Native Studies Elective	3

*In the third year of studies, the nursing students participate in NPRs related to medicine and surgery.

Year in the Program	Faculty or Department	Course	Credit Hours
4	Nursing	Palliative Care	3
4	Nursing	Mental Health and Illness	3
4	Nursing	**Clinical Practice 5***	4
4	Arts	Humanities Electives	6
4	Nursing	Leadership: Issues and Practices	4
4	Nursing	Health Promotion in the Community	3
4	Nursing	**Clinical Practice 6***	3
4	Nursing	Prevention of Illness	3
Third and final semester	Placement in nursing practice setting	**12 week Senior Practicum**	10

***In the fourth year of studies, the nursing students engage in NPRs for palliative care and mental health, and community health.

Nursing practice rotations. A nursing practice rotation (NPR) (i.e. clinical practice) was a facilitated nursing student experience in an area of nursing practice (in a hospital, facility, or community within the local regional health authority) who had established agreements with the Faculty of Nursing. The main purposes of NPRs were to: orientate nursing students to the various areas of nursing practice, ensure the safe practice of students as they learn to care for clients, and integrate nursing theory and practice (Associate Dean of Undergraduate Nursing Programs, Faculty of Nursing, personal communication, November 6th, 2013).

Nursing students were placed at various NPR sites based upon their year and semester in the undergraduate program (see Table Two). Occasionally, nursing students were placed in rural, northern, or international health care settings, particularly in their final nursing practice rotation, *Senior Practicum* (SP).

Table II: Nursing Practice Rotations in Faculty of Nursing

Year in Nursing Education	Area of Nursing Practice	Length of Time in Practice	Nursing Student to Client Ratio
2nd	Maternity-child	12 weeks = 6 in hospital and 6 in community	1:1
	Gerontology	12 weeks=6 in facility and 6 in community	1:1-2
3rd	Medicine	9 weeks in hospital	1:2-3
	Surgery	9 weeks in hospital	1:2-3
4th	Mental Health and Palliative Care	8 weeks=4 with Mental Health and 4 with Palliative Care	1: 1-2
	Community Health	12 weeks	Client teaching = 1:1 or 1: groups
Senior Practicum	Placement at Student's request	450 hours	To full patient load

At each site, a *Clinical Education Facilitator* (CEF) who was a contract employee of the Faculty of Nursing instructed, guided, and evaluated a group of six to seven nursing students as they cared for their assigned clients. Because the CEFs are typically experts in their area of nursing practice, yet had received limited formal education in pedagogy or teaching and learning strategies, CEFs reported to a *Course Leader* (experienced faculty member who oversaw the clinical nursing *course*) or *Site Leader* (an experienced faculty member who oversaw all clinical nursing courses *at that practice site*) when they had questions regarding instruction, student discipline, site concerns, or student evaluations.

Within health care facilities, each student's assigned client also had a staff nurse or Registered Nurse, known to the students as a *Buddy Nurse* (BN), who coached the student to care for his/her client to the extent that the student was able (in knowledge and skills) to provide safe

competent care. Most importantly, the above roles and relationships shaped nursing students' experiences of interpersonal communication on NPRs during the second, third, and fourth years of their undergraduate nursing education.

Because the focus of this study was nursing students' lived experiences of interpersonal communication on NPR includes Senior Practicum (SP) (the students' final NPR), some unique distinctions regarding SP must be explained. In SP, students were placed in their intended or favoured area of professional nursing practice, and some SP placements did lead to employment as a graduate (novice) nurse. In a recent provincial survey (Manitoba Centre for Nursing and Health Research, 2015), 76% of new graduate nurses obtained their first nursing positions in the same facility as SP placement. In this way, some nursing students viewed SP as an extensive job interview. At the site, each SP nursing student worked with a *Preceptor* (P) who was an experienced staff nurse in this area of nursing practice and who gradually coached and guided the student to reach a full client load (also known as *patient load*) and meet entry level competencies. The student was also assigned to a faculty member (called a *faculty advisor*) who worked with the P to guide and evaluate the student in this final nursing practice rotation in the undergraduate nursing education program.

Therefore, Senior Practicum was intended to be the consolidation of learning from the various Nursing courses and previous clinical experiences as the student became increasingly independent. As such, nursing students in this study drew upon experiences from all of their prior nursing experiences with nurses and clients. Moreover, the conceptual framework for this study represented the extent to which embedded relationships shaped the interpersonal communication of nursing students during their education.

Nursing practice culture. In the present study, NPRs also integrated students into the practice culture of nursing in various clinical (health care) contexts or units. As nursing students are being inducted into this culture, their lived experiences can be a struggle because they are not only adapting to nursing in terms of content and skills, they are recreating themselves as nurses. Communication is part of the role development of the nurse, for students construct their identity as nurses over time through communication (Habermas, 1987). Habermas's theory of communicative action is a typology theory (Heath, 2003) in which language is used to determine a set of shared goals or coordinate social action when the speaker takes different stances or modes necessary to performing particular types of actions (Habermas, 1987). Nursing students must learn to make affective shifts from different types or modes of being, that include: the technical mode necessary to performing nursing skills, the caring mode for interacting with clients and their families, to the nursing student mode for reporting to and learning from more experienced nurses.

Power plays a role within this professional role development because the success of nursing students is predicated on the student's ability to move into the culture of nursing and learn to operate in the power dynamics of that culture. Nursing students learn to look and act like nurses in the health care system by replicating the professional skills, attitudes, and behaviours of experienced nurses expressed through communication (Brown & Middaugh, 2009). Thus, nursing student participants in this study were asked about their perceptions of nursing culture and the extent to which that culture influenced their development of interpersonal communication with nurses and clients. In this way, I examined the position of nursing students and the experiences and perceptions of their interpersonal communication.

In the academic literature (Lally, 2009; Lewis, 2006; Rowe & Sherlock, 2005), nurse scholars have described the role of power in the nursing practice culture as an organizational culture of nurses who eat their young (Bartholomew, 2006; Joseph, Laughton, & Bogue, 2011). Some NPRs are a great source of stress for nursing students due to, not only the students' inexperience, but as a result of the negative attitudes of some experienced nurses who consciously or unconsciously demonstrate the belief that nursing students must 'pay their dues' (as they did) in their socialization into the profession (Johnson, 2009).

However, nursing practice culture is better understood within the context of the history of nursing as a profession and academic discipline. Since the late 1800s, nursing students' experiences within the nursing practice culture have been shaped by such factors as: the individual nurses' attitudes, behaviour, and communication on that unit; the processes, procedures, and policies of the unit or health care facility in times of depression, war, and stability; Canada's costly universal health care system; society's perceptions of the role of the nurse; and the biomedical model which operates within the hierarchical health care system. The nursing student adapts to the nursing practice culture and becomes a nurse through communication within a larger system at a particular moment in time.

Lived Experiences of Nursing Students in Nursing Practice Rotations

Nursing students commonly struggle to become accustomed to the sights, noises, and smells of a care facility and being faced with illness, pain, suffering, and the associated physical and emotional manifestations of the clients (Eifried, 2003; James & Chapman, 2010; Kostovich & Thurn, 2013; Loftus, 1998; Pedersen & Sivonen, 2012; Sorrell & Redmond, 1997). No matter the year of study or NPR, nursing students reportedly felt overwhelmed by the range of nursing skills, knowledge, and interpersonal communication necessary to practice the nursing role, which

they expressed as feeling useless, intimidated, inadequate, vulnerable, anxious, uncomfortable, getting in the way, knowing a little, disorientating, afraid, and confronting (Callagan, 2010; Chesser-Smyth, 2005; Foley et al., 2012; James & Chapman, 2010; Melincavage, 2011; Pedersen & Sivonen, 2012; Reese, 2013; Rohde, 1996).

When nursing students cannot cope or adapt to the nursing role, their interpersonal communication is impacted. Research into the lived experiences of nursing students on NPRs consistently demonstrates that: (a) positive nurturing relationships with nurse educators provided students with the guidance and confidence to communicate effectively with clients and other nurses on the NPR, while (b) negative relationships with nurse educators and other nurses had the opposite effect of discouraging students and disabling confidence to care and communicate with others (Baglin & Rugg, 2010; James & Chapman, 2010; Papp, Markkanen, & von Bonsdorff, 2003; Thorkilsen & Raholm, 2010). Similarly, Habermas (1987) claimed that what one says (one's *speech act*) establishes the normative relationship between the speaker and listener(s); however, when *mutual understanding* between the speaker and listener (or recipient of the communication) does not occur and communication breaks down, the speaker cannot become part of the *lifeworld*, the norms or consensus of that context (Thomassen, 2010). In this way, positive relationships with nurse educators foster not only the student's communication, but his or her adaptation or integration into to the culture of nursing.

In the design of this study, I chose to interview nursing students upon completion of their final nursing practice rotation, Senior Practicum. I selected this juncture because the nursing students had not only completed several NPRs in various areas of nursing, but most importantly for this study, the nursing student had had numerous opportunities to engage in relationship and interpersonal communication with many different nurses and clients. At this moment, the nursing

students were formally educated, yet not fully socialized into the nursing profession and were still relatively new to the established norms of relationship and the negotiation of power in the nursing field. Therefore, after completion of SP was the optimal time to examine what the nursing students believed they had learned from experiences of interpersonal communication as part of their nursing education.

Research Questions

The principal research question was as follows: Upon completion of Senior Practicum, what were the lived experiences and perceptions of nursing students' interpersonal communication during NPRs in two basic modalities: (a) with clients and (b) with nurses? This question was intended to identify the extent to which nursing students were aware of the roles and relationships in the context of NPRs and how such awareness shaped nursing students' interpersonal communication with clients and nurses. Sub-questions examined:

- What were nursing students' understandings and experiences of their interpersonal communication in nursing?
- What were the factors (both personal and contextual) that promoted or hindered students' abilities to communicate effectively with clients and nurses during NPRs?
- How did nursing students define and describe the practice culture of nursing, and how did they make sense of interpersonal communication within that culture?

Definitions

In the context of this study, *interpersonal communication* referred to: (a) the behaviour of face-to-face messages, in the form of words or oral language, non-verbal/body language, and proxemics (the spatial distance between individuals) to complete a specific nursing task/goal, as well as (b) the attitudes and relationships which shaped interactions and power during nursing

practice. *Personal factors* included factors related to a specific nursing student such as his or her personality and capabilities, as well as the individual's familial or cultural experiences that shaped his or her attitudes towards authority figures in education or the health care system. *Contextual factors* were those factors relative to the specific context of the NPR, such as the number of staff, demands and expectations on the unit, or work place culture. *Effective communication* was communication that promoted health and healing as part of nursing care, preserved the client's dignity and autonomy (CNA, 2008), imparted *caring nursing practice* (Watson, 2008), and, in this study, included nurse-to-nurse communication.

Significance of the Study

This study is significant for three main reasons. First, nursing research in communication is extensive yet remains broad in nature because present and past definitions of communication in nursing have included two modes or forms of communication (nurse-client communication and nurse-nurse communication), and these definitions lack a consensus of meaning or intention. The present study is unique in that communication is focused on *interpersonal communication* in nursing (the behaviours, roles, and relationships). Second while previous studies have focused on the lived experiences of nursing students in NPRs (James & Chapman, 2010; Pederson & Sivonen, 2012), the present study is distinctive in that it focused on the specific *interpersonal communication* of nursing students with nurses and clients. Third, extensive literature has emerged on the relationships between nursing students and other nurses (Bartholomew, 2006; Johnson, 2009) including on NPRs (Lally, 2009). This study extends this body of research by examining in a more elaborated and systematic manner the specific experiences of nursing students as they were socialized into the profession of nursing through NPRs. Moreover, this study is unique in that it focused on students' lived experiences across NPRs. In this study, I

developed an elaborated framework to understand nursing students' lived experiences upon completion of the SP when students had been exposed to several NPRs and numerous nurse and client interactions therein.

Theoretical Frameworks

Because this study necessitated a thoughtful consideration of the system of layers of roles and relationships inherent in nursing education as well as a critical lens on the entrenched power struggles inherent in nursing and nursing education, Bronfenbrenner's Ecological Systems Theory and Critical Systems Theory were employed as complementary approaches to the topic. What follows is a brief discussion of each theoretical framework and the ways in which the frameworks were used to guide this study, including the interview questions.

Ecological Systems Theory

Ecological Systems Theory (Bronfenbrenner, 1979) is a theory of development and was applied to this study because nursing students are developing in the context of communicative interactions. Bronfenbrenner's (1979) *Ecology of Human Development* was an appropriate conceptual framework for this project because his work considers the individual as part of a larger system of relationships. Bronfenbrenner maintained that a person's development is "the product of a constellation of forces-cultural, social, economic, political-and not merely psychological ones" (Cesi, 2006, p. 174) and his model in the *Ecology of human development* (1979) hypothesizes or describes the ways that individuals are shaped by/through different kinds of relationships within their environment. In the present study, the ecology was nursing education, and the NPR was this ecology. Thus, the nursing student's environment included relationships relevant to the: NPR, hospital or community health care, undergraduate nursing program, and nursing practice culture. In this way, the nursing students were embedded within

dynamic reciprocal relationships called systems (the microsystem, mesosystem, exosystem, macrosystem and macrosystem within time, chronosystem). Below, each of Bronfenbrenner's systems of relationship is discussed in relationship to this study.

Microsystem. Microsystems are settings in which the individual "has direct face-to-face relationships with significant people" (Leonard, 2011, p. 990) who shape the activities and interpersonal relationships of a given role (Bronfenbrenner, 1979). Within the context of this study, the microsystem is made up of the nursing student's face-to-face relationships with CEFs and clients that shaped the role of the student in the NPR (Bronfenbrenner, 1979). This nursing student role shaped the individual's behaviour and expectations within these relationships, for "[r]oles have a magic-like power to alter how a person is treated, how she acts, what she does, and thereby even what she thinks and feels" (Bronfenbrenner, 1979, p. 6). Moreover, an individual thrives in the microsystem when he or she communicates in a number of "structurally different settings wherein relationships may be formed with 'more mature or experienced' individuals" (Bronfenbrenner, 1979, p. 212), which I interpret to mean that nursing students thrived in the microsystem when they formed relationships with CEFs and clients.

A valuable aspect of Bronfenbrenner's definition and description of the microsystem is the attention he pays to *individual experiences and perceptions* of the activities, roles, and relationships in one's environment (Bronfenbrenner, 1979). Therefore, the interview questions related to the microsystem were: What were your experiences with your clients like? What did you find challenging and what did you find rewarding about these interactions? In your experience, what was the role of the CEF? What were your relationships with your CEFs like? How did your relationships with your CEFs shape your experience of clinical practice? Can you give me some examples?

Mesosystem. Mesosystems include "the interactions among two or more settings in which each developing person actively participates", in other words, it is "a system of microsystems" (Bronfenbrenner, 1979, p. 25). Within this study, the nursing student's mesosystem was constituted by the student's relationships with Course Leaders, Site Leaders, Preceptor, and Buddy Nurses because these roles implied responsibilities and relationships to several microsystems within which the nursing student participated. To illustrate, the Buddy Nurse was responsible for the safety and care of the client on the unit while guiding the student nurse. The Course Leader, Site Leader, and Preceptor had to respect the regulations and goals of both the health care institution of the NPR and faculty of nursing while supporting the education of the nursing student.

Consequently, the interview questions about the mesosytem were: What was the role of the Buddy Nurse in clinical practice? What was the role of the Course Leader? How did these nurses shape your clinical practice experiences? Can you give me an example of a memorable nurse who communicated effectively with clients? What did you learn from this nurse?

Exosystem. An exosystem is "one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in that setting containing the developing person" (Bronfenbrenner, 1979, p. 25). In this study, the nursing student's exosystem included the settings that did not directly involve the nursing student as an active participant, yet the processes, procedures, or expectations of these settings affect, or were affected by, the nursing student's ability to communicate interpersonally as part of their care (Bronfenbrenner, 1979, p. 25). More specifically, the nursing student's exosystem included: (a) policies, procedures, and assignments of the faculty of nursing for the NPR and SP, and (b) the *Standards of Practice* set and maintained by the College of Registered

Nurses of Manitoba (2007) that were used as benchmarks to set curricular objectives for the NPR and the College's administration of the RN Licensing Examination which students completed following their nursing education. Many of the competencies in the *Standards* were related directly to effective interpersonal communication.

The interview question related to the exosystem included: To what extent were the assignments in clinical practice helpful in learning to communicate with clients and other nurses?

Macrosystem. Bronfenbrenner's macrosystem is in reference to the "...consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exist or could exist at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies" (1979, p. 26). Stated another way, the macrosystem entails the influence of the culture or the society upon the beliefs of individuals or public institutions. In this study, the macrosystem was in reference to the influence of the nursing practice culture and the way in which that culture manifested on the specific nursing unit upon the beliefs of individual nurses, nursing students, and nurse educators in NPRs and SP. This culture is regenerated and continued through the process of nursing education and socialization of nurses, at least in part through communication. These cultural vantage points and expectations are certain to impact upon nursing students' interactions with clients and other nurses.

As a result, the interview questions for the macrosystem were: As you completed your nursing education, what were your impressions of nursing practice/the practice of nursing? What did being a nurse mean to you now compared to what it meant to you when you started your nursing education? What were your most important lessons in nursing education that you felt prepared you to be a nurse?

Chronosystem. The fifth and final system, Bronfenbrenner's (1979) chronosystem includes the environmental events, significant life transitions, and historical events in one's life. In the current study, the chronosystem influenced the development of the nursing student in that, nursing education and socialization to the professional role of a nurse is a significant life transition that has an impact on the lifetime of the individual. Moreover, the historical moment in time within which nursing students engaged in nursing education, 2010 to 2014 in this study, was relevant because the participants were part of a generation of nursing students, the Millennials. This generation of nursing students are learning from an aging nursing workforce of Baby boomers who may not have shared some of the same values or priorities (Mitchell, 2012), yet Millennial nursing students were more prepared than previous generations for the technologicalization of health care (Fater, 2010; Lower, 2008; McCurry & Martins, 2010). As nursing students make the significant life transition to the role of the nurse, they face challenges that are unique to their moment in the development of the nursing profession and nursing education.

Lastly, the interview questions that elicited the chronosystem were: Based on your experiences in clinical practice, what made you feel excited or fearful about a career in nursing? What kinds of challenges and opportunities did you and your classmates face compared to older more experienced generation of nurses? What advice would you have had for a new nursing student?

In summary, a nursing student participant in this study was engaged in relationships within a number of systems, yet this individual had varying degrees of direct interpersonal communication, connection, and influence within each of these systems. However, Bronfenbrenner's framework has limited application in situations of conflict due to his essential

assumption that relationships are rational means for making correct and optimal decisions in an impartial way (Flood, 1990; Jackson, 2010). In reality, differences in power and influence shape nursing education in the NPR and SP. For instance, Course Leaders and Site Leaders were nursing faculty who were in roles of significantly more stability, financial remuneration, and power compared to the roles of contract clinical educators in the practice settings. While Bronfenbrenner's model allowed for a clear *description* of the status quo, ecological systems theory alone was a somewhat naive approach to understanding one of the key forces that drove and shaped nursing, *imbalances* of power. For this reason, critical systems thinking was also employed in this study so that Bronfenbrenner's interdisciplinary systems theory was built upon in a way that further demonstrated the complexity of interpersonal communication in nursing education.

Critical Systems Theory: A Critique of the Status Quo

Critical Systems Theory (CST) emerged from the writings of Ulrich, Jackson, Keys, Mingers, Oliga, and Midgley who have explored the way an individual can make choices in a critical manner (Midgley, 2000; Oliga, 1999; Stephens et al., 2010a) within unjust and undemocratic economic, social and political systems and practices (Flood, 1990). Critical Systems Theory (CST) was used as a conceptual framework in this study to explore the extent to which nursing student participants critically viewed their interpersonal communication within the hierarchical power structures of nursing roles and relationships with nurses in the NPRs (Flood, 1990; Midgley, 2000; Oliga, 1995).

Critical theory not only disrupts the status quo, it does so systematically based on the theoretical perspective being applied. In this study, Habermas (1987, 1984) whose typology of communication permits an assessment of the structural type and situation of the action served to

operationalize CST. Habermas (1984) claimed that conflict is due to a lack of communication. As nursing students learn to make affective shifts from different types or modes of being (Habermas, 1987), tensions (varying forms or degrees of conflict) are developed due to gaps between what an individual nursing student is able to do and what this nursing student is expected to do. As these tensions develop, nurse educators and nursing students negotiate this gap within the established hierarchies of power described in Chapter Two. Therefore, communication is means by which this negotiation of power occurs.

CST is built on: (a) the democratic goals of the work of Jürgen Habermas (1970) who was interested in revealing the possibility of emancipation within organizations, institutions, societies, and other social groupings in response to dominance and subjugation by others; (b) the socialist ideas of Karl Marx (1848) who examined inequities and exploitive relationships in capitalist societies; and (c) the post-modernist interpretations of Michael Foucault who explored power, knowledge, and social behaviour within the social order (Flood, 1990; Pollack, 2006). Most notably, Foucault's contribution to CST is an analysis of ways in which "those disciplining and those disciplined are caught within self-reproducing relations of power" (Garnsey, 1993, p. 240). Thus, CST theorists aim to integrate theory and ideology. CST was useful in this study because I explored nursing students' interpersonal communication beyond Bronfenbrenner's description of the various systems. I was also interested in the power relationships in nursing education that have been reproduced over generations of nurses, and CST theorists explore the ways that *coercive contexts* are re-enacted and reproduced across generations (Flood, 1990; Midgley, 2000; Oliga, 1995). Coercive contexts are defined by critical systems theorists as "situations where there is little common interest shared between stakeholders, there is

fundamental conflict, and the only consensuses that can be achieved arise from the exercise of power" (Jackson, 2001, p. 237).

Historically, nurses have been exploited within a Canadian health care system that attempts to provide universal care within financial constraints (Mansell, 2004) and that has largely seen nurses as subservient temporary workers (McPherson, 2003). Nurses continue to practice within a hierarchy that affords them limited power, despite the evolution of nursing as a professional discipline in its own right (Manitoba Nurses Union, 2003). During their NPRs, nursing students enter nursing practice contexts within which the nursing practice culture has ingrained power struggles that play out among nurses and that are reproduced during the education and socialization of nursing students and newly graduated nurses (Hayward, 2014). Within the research study, I was specifically interested in the extent to which generational differences between (a) the predominantly Baby Boomer generation of nurses and nurse educators and (b) the primarily Millennial nursing students led to conflict in the NPR and the ways that the nursing students' interpersonal communication with nurses and clients were impacted as a consequence. I was interested in students' awareness of power and how they made sense of it. More specifically, I wanted to learn if nursing students' lived experiences of interpersonal communication included being directly or indirectly taught to be subservient or submissive to other nurses or clients' needs in the NPR, as the case has been with physicians and hospital administrators. Furthermore, I was curious to hear from the students if they had any experiences of resistance in which a nurse or the student him/herself spoke up or out against coercive contexts within the NPR. The interview questions intended to elicit this information from the participants were: As a nursing student in clinical practice, did you witness or experience any conflict? Among whom? How did nurses communicate in such situations? How

did you react to conflict? How did this conflict impact or influence your ability to communicate with clients or other nurses?

CST theorists contest hierarchical power structures and stress the need to build shared understandings and participatory decision making (Stephens et al., 2010b). With CST as a conceptual framework of this study and the work of Habermas as operationalizing the CST, I used a critical lens to determine: the extent to which nursing student participants were aware of any power struggles within the NPR, what (if any) forms of aggressive behaviour nursing students experienced (physical, emotional, psychological, or social), and, most importantly, the ways in which any experiences of power struggles impacted the students' ability to effectively engage in interpersonal communication with nurses and clients in the NPR. Conversely, I was also interested in the ways that nurse educators supported students and encouraged their interpersonal communication with nurses and clients in the NPR.

The interview questions intended to open discussion on these topics were: How did nurses supported or nurtured your development into a nurse? To what extent have nurses helped you learned to communicate situations involving conflict?

Because the three central concerns of CST are to "social improvement, liberation from oppression with a commitment to achieving mutual understandings, and address issues of power and coercion" (Flood, 1990; Midgley, 2000; Oliga, 1995), a study on interpersonal communication within the nursing culture had to also employ a CST lens to achieve a deeper understanding of why nurses interpersonal communication is not only shaped by roles and relationships, as Bronfenbrenner implies, but also by power.

CHAPTER TWO: REVIEW OF THE LITERATURE

In the phenomenological research method used in this study, the purpose of the review of the literature is for the researcher to engage with the phenomenon prior to data collection to consider his or her prior awareness, anticipation of meaning, and perceptions rather than bracketing these presuppositions (van Manen, 1990). Therefore, the scholarly literature in this chapter was explored, *not only* to familiarize myself with prior research but to ground this study within the work of previous studies. The literature was used to: (a) clarify my own prior understanding of the lived experiences of nursing students' interpersonal communication in Nursing Practice Rotation (NPR)s, (b) consciously carry this understanding into the data collection to remain cognizant of which lived experiences and perceptions belonged to the participants and which perceptions were my own, and (c) link the existing literature to Ecological Systems Theory (EST) and Critical Systems Theory (CST), the two theoretical frameworks in this study.

In this chapter, I engaged with five categories of literature relevant to the lived experiences of interpersonal communication by nursing students. First, I explored the literature on nurse communication as nursing increasingly became a distinct profession and discipline of scholarship. The varying historical and contemporary definitions of nurse communication have informed the term I have chosen to use as an investigative concept, interpersonal communication in nursing, a systems attribute which brings several of these definitions together. Second, I sampled the literature on communication among professional nurses in nursing practice settings to shed light on the ways that power relationships are reproduced between nurses, a situation that critical systems theorists define as a coercive context (Flood, 1990; Jackson, 2001; Midgley, 2001). The literature on norms within nursing practice culture led me to choose the framework of

CST for this study as CST exposes power relationships and examines the ways these coercive contexts are reproduced across generations of nurses. Third, I reviewed the literature on communication between nurse educators and their students on NPRs, for this body of scholarship demonstrates how generational characteristics and belonging (or not belonging) on NPRs impacts students' communication with nurses and clients. Communication is shaped by the different kinds of relationships within one's environment (as per Bronfenbrenner) as well as the negotiation of power between individuals (as per critical systems theorists). Next, I considered communication between nursing students and their clients (Callagan, 2011; Fagerberg & Ekman, 1997; Holström & Larsson, 2005) as this research demonstrates students' common lack of emotional preparedness for NPRs, which in turn, influences their efforts to communicate and sustain relationships with their clients. This literature was invaluable in understanding the face-to-face relationships between participants and their clients at the microsystem level of EST in this study. Lastly, I found that phenomenological studies directly related to nursing students' lived experiences on NPRs (Eifried, 2003; Pederson & Sivonen, 2012; Rees, 2013) reiterated the importance of relationships and roles within differing systems of EST, and power in nursing education inherent in CST from the point of view of nursing students.

The Evolution of Nursing Communication

Defining Communication

To develop a definition of *interpersonal communication in nursing practice* for the purposes of investigating nursing students' experiences of interpersonal communication with nurses and clients in the NPRs in this study, it was essential to consider the evolution of communication between nurses and clients. An essential premise of the ensuing discussion is that the roots of the varying definitions of communication in nursing are grounded within the

development of the discipline and profession of nursing. The literature in this first section demonstrates that the social construction of the nurse (including the communication of nurses) changed in response to the development of Canadian nursing. More specifically, I will illustrate the ways that: historical and environmental events changed nurses (and their communication) at the systems level of the microsystem (the face-to-face relationships between physicians, nurses, and clients), the macrosystem (societal beliefs about nurses and their place in health care), and the ecosystem (the standards policies, and procedures of the nursing profession).

The body of literature on communication in peer reviewed nursing journals and texts demonstrates the evolution of nurse-client communication theory as the profession of nursing espoused values were articulated within the scholarship of an increasingly independent discipline in post-secondary institutions. The historical foundations of communication of nurses are found in: psychiatry and psychology (Coon & Mitterer, 2008; Freud, 1995; Stevens, 2008); medicine and other areas of healthcare (Kooienga & Stewart, 2011; Kreps et al., 1994; Maguire & Pitceathly, 2002); professional bodies of nursing (CNA, 2011, 2008, n.d.; CRNM, 2013); as well as current and seminal articles in nursing (Patterson & Zdenak, 1976; Schulz, 2008; Watson, 2008; White, 2012). In this wide ranging literature about nursing in various contexts, communication has been defined as: a process (Dreger, 2001), a developmental issue (Berglund & Saltman, 2002), an intervention and skills-based competency (Bick, 2010; Gruber & Hartman, 2007), and a means to create and sustain relationship (Hartrick, 1997; McHugh Schuster & Nykolyn, 2010). Therefore, communication in nursing is examined in this first section of the literature review as a process, a developmental issue, an intervention, and a relationship in light of the relevant systems of Ecological Systems Theory (EST) and the central tenants of Critical Systems Theory (CST).

Communication as a process. "I see and am silent" was the motto of the first nursing school in Canada (Rankin, 1998, p. 6). This statement reflects the position of nurses for whom silence was the dominant discourse in nursing practice (Bradbury-Jones, Sambrook, & Irvine, 2008). At the outset of the profession, Canadian nurses' duties included observing clients and reporting their findings to physicians to whom they were subordinate (Mansell, 2004). Communication was a process of the nurse giving messages to the physician and receiving orders from the physician (Dreger, 2001; McHugh Schuster & Nykolyn, 2010) for the purpose of determining what ailed the client and how that ailment might be treated or cured. When nurses' communication was a matter of following this process, they were largely powerless to advocate on behalf of themselves and their clients. In this way, the nurse's communication was shaped by her (as nurse were predominantly women at this time) relationship to the physician (who was most commonly male during this moment in history) (Mansell, 2004). In fact, the role of the nurse shaped how she was treated, how she acted, what she did, and the extent to which she was able to communicate her thoughts. Hence, these settings of nursing practice existed at the systems level of the microsystem as face-to-face gendered relationships shaping the activities and relationships of a given role (Bronfenbrenner, 1979).

This early definition of communication as a nurse originates in the dominant model of health care delivery since the early 20th century, the technological paradigm or bio-medical model that focuses on diagnosis, treatment, and evaluation of clients (Barker, 1998; The Open University, 2012). Between 1870 and the First World War, advances in medical knowledge, such as the microscope and chloroform, were part of the Canadian public's increasing faith in "the power of science" (Mansell, 2004, p. 21). Within this climate, however, the inceptions of Canadian nursing were grounded in religious nursing orders (Canadian Nursing Association

[CNA], 2013) and Florence Nightingale's legacy, both of which isolated nurses from Canadian society in homes specifically for nurses at (or near) the hospital (Mansell, 2004; McPherson, 2003). Nurses' discourse of silence was consistent with Victorian notions of good female comportment (McPhereson, 2003). Therefore, the earliest socialization of nurses was shaped by communication at the systems (Bronfenbrener, 1979) level of the macrosystem, the beliefs or ideology at the level of the society or culture, that nurses (as women) must know their place. This process of communication in which nurses were expected to swallow their words or bite their tongues began to change as nurses banded together to develop the first nursing organizations in Canada (CNA, 2013).

Communication as a developmental issue. Over the early half of the 20th century in Canada, the profession and discipline of nursing developed, and the nursing role matured as a consequence. Communication was the means by which nurses organized and educated themselves through a professional body and university education. In this next phase, communication was a developmental issue in nursing, for the nurse needed to have a developed or mature sense of self in order to empathize with the experiences of clients and communicate her ideas effectively as nurse to engage in new contexts of care (Berglund & Saltman, 2002). Stated another way, the nurse's ability to communicate was "intertwined with identity formation and cognitive capacity" (Berglund & Saltman, 2002, p. 9), a notion which is retained in the definition of interpersonal communication used in this study.

The efforts of nurses to communicate their identity formation and development were represented in nurses' efforts to become a profession in the first half of the 20th century. The contribution of nurses to Canada's effort in the First World War and the Spanish Flu Epidemic between 1914 and 1919 allowed nurses to work more independently of medical supervision

(Mansell, 2004). The provincial registration of nurses and the establishment of university education for some nurses in the 1920s and 1930s (McPherson, 2003) were developmental milestones in nursing's goal of professionalism. Nurses were developing their independence as health practitioners and engaging in the knowledge of health sciences at the time.

Unfortunately, this "pursuit of professionalism [was] met with opposition by both the medical profession and the public" (Mansell, 2003, p. 65) who communicated their view that nurses were to remain assistants or "handmaidens" of physicians within prescribed feminine roles of the time (Manitoba Nurses Union [MNU], 2003, p. 10). For instance, injured soldiers continued to call nurses in their blue dresses and white aprons "Bluebirds" or "Angels of Mercy" (McMaster University, 2013, para.1). In this way, the identity formation of nurses was hindered at the level of the culture and public opinion shaped by that culture (the macrosystem [Bronfenbrenner, 1979]). Canadian public and legal society was not ready to communicate with nurses 'on an equal playing field' at home on hospital wards or on the foreign battlefields. More specifically, public opinion and that of the medical community had an impact on the nurses' roles and relationships, including their communication within those roles and relationships. Beliefs about women in general and nurses in particular dominated and discouraged nurses' efforts at professionalization during this period in Canadian nursing history. While some individual nurses during this era increasingly found their voices and argued against the exploitation of their services by Canadian hospitals (McPherson, 2003), in the 1920s and 1930s, nursing needed to formalize as a professional organization before their voices could be heard.

Since communication is viewed as a developmental issue in the present study, it is therein the responsibility of nursing education to help the nursing student mature in his or her self-awareness, and the awareness of others' needs, to prepare this individual to communicate in

nursing practice given the impact of the macrosystem (social and public opinions of nurses and nursing). In the 1940s, nurses had further opportunities to practice in contexts that would develop and improve their nursing skills, including their communication skills.

Communication as a skill. In the years surrounding the Second World War, attempts to improve the standards of nursing education and the experiences of front line nurses in the war, forged the notion that communication is "an essential intervention and a skills-based competency" (Bick, 2010, p. 378) in which a nurse acquires concepts such as effectiveness, sensitivity, and appropriateness within a context (McHugh Schuster & Nykolyn, 2010). Communication skills and behaviours that indicate communication competence include: "the ability to advise and instruct others, issue orders, provide clear information, listen effectively, manage conflict, persuade others, speak articulately, speak in public, routinely exchange information, participate in small group discussion, use appropriate humor, empathize, negotiate, and operate autonomously" (Gruber & Hartman, 2007, p. 14).

These competencies originate in the professional regulating bodies for nursing such as the Canadian Nurses Association (CNA) who established and maintained competencies and standards of practice that necessitate communication competence. The College of Registered Nurses of Manitoba (CRNM), which celebrated its Centennial in 2013 (Manitoba was the second Canadian province to register nurses in February, 1903), promotes the position that entry level competencies for Registered Nurses are predicated on the understanding that the Registered Nurse (RN) can communicate effectively using a range of communication skills with clients, families, and health care professionals (CRNM, 2009a; CRNM, 2013). These competencies were the basis for the curricular goals or outcomes of the undergraduate nursing curriculum, *The conceptual framework for the curriculum*, in this study (Faculty of Nursing, University of

Manitoba, 2005). The exosystem or those processes, procedures, and expectations of these settings that affect the nursing students' ability to communicate as part of their care. In this perspective, nursing students learn to communicate to meet nurses' goals of care and to advance nursing practice. As nurses were developing a collective voice as a professional body, nursing students were socialized to follow these new procedures, processes, and expectations of the new profession (the ecosystem in the present study).

Similarly, since its inception in 1908, the mission of the CNA has been to promote and advance the practice of nursing and the roles of nurses in order to improve health outcomes (CNA, 2011). As early as the 1920s, CNA leaders attempted to raise educational standards for nursing to "construct a body of knowledge that would define the trained nurse" (CNA, 2013, p. 4). Nevertheless, prior to World War Two, the interest in improving nursing education went unrealized because nursing students provided hospitals with a cheap source of labour (CNA, 2013). Allowing nurses and their students to communicate their competence was not within the larger institutional goals of keeping health care costs low, a theme that remerges in the recent history of nursing in Canada. In these ways, nurses were subject to the unjust economic and political systems and practices of the Canadian health care system. Through the lens of CST, it appears that the hierarchical power structures of Canadian hospitals and governments who funded health care superseded the goals of the nursing profession.

When nurses joined the war effort in World War Two, military nursing provided an opportunity for nurses to participate in scientific advances and to demonstrate their skills and knowledge to other health care providers and Canadian society (Mansell, 2004). As a result, nursing was increasingly seen as a clinically skilled role in post war years (Mansell, 2004;

McPherson, 2003). In this view, nurses communicated to demonstrate their skills as health care professionals in their own right.

While nurses made considerable gains in demonstrating their skills during WWII, nursing education in Canada experienced its own 'time in the trenches' related to gendered notions of the nursing profession. Nurse educators made decisions about which women may or may not become nurses based on the beliefs and ideology of the society at the time. By 1948, many Canadian nursing schools still did not accept married or pregnant women, and many hospitals would not employ a married nurse. Thus, nursing and nursing education upheld the ideology and beliefs of the culture or society (the macrosystems level of EST [Bronfenbrenner, 1979]) by limiting the career longevity of women who entered the nursing profession.

Working nurses faced long hours, low salaries, few holidays, and instability (MNU, 2003). These labour practices in Canadian nursing continued until the 1960s (McPherson, 2003). The standards, competencies, and practices of the time meant that nurses were expected to be skilled and more outspoken communicators, yet their labour was poorly recognized in terms of compensation, benefits, stability, and rights that the lens of CST identifies as unjust and inequitable practice. Nurses in practice and nurse educators on university campuses were to educate and socialize nursing students to be diligent professionals in their care and communication despite the lack of recognition for their labour. This inequitable relationship between the Canadian health care system or administration at care facilities and nurses persisted into the 1960s when nurses were forced to new ways to communicate to move the profession forward.

Communication as relationship. Communication has also been defined in research about communication as the means by which the nurse-client relationship takes place (Arnold &

Boggs, 2003). In this instance, communication as relationship is in relation to the systems level of the microsystem, the nurse's face-to-face interactions with individuals significant to her/his role and who shape the activities and relationships of this role, in this case, the client (Bronfenbrenner, 1979). The focus is on the perceptions and experiences of the individual (nurse) within the (care) environment. Relationships are built in the meanings or perceived reality of the interactions between the nurse and client.

Most importantly for this study, communication provides the method for nurses and clients to interact, share feelings, ideas or expectations, establish common ground, or exchange information (Dreger, 2001); in other words, communication is for the social construction of client care. Good relationships in nursing are subsequently built and sustained through good communication (Gruber, 2007). This notion of communication reflects the core humanistic values of nurses, such as caring nursing practice. Behavioural approaches to the nurse-client relationship as a process, a developmental issue, or a skill-based competency have been challenged by nursing theorists since the 1970s who proposed interpersonal models of practice that were reflective of the values of nursing [see: Paterson & Zderad (1976) (humanistic nursing), Carper (1978) (fundamental ways of knowing), and Leininger (1988) or Watson (1988) (concept of caring)]. When communication is intended to create and sustain nurse-client relationships, nursing education promotes the values of nurses, and nursing students learn to convey these values through their communication.

This definition of communication as relationship can also be extended beyond the face-to-face nurse-client relationship because post war nursing in Canada has also been largely about the relationship between nursing unions and health care institutions (the systems level of the exosystem) and at the level of the general public (the systems level of the macrosystem

[Bronfenbrenner, 1979]) (McPherson, 2003). Nurses in Canada formally unionized in the late 1960s to address the need for care services due to nursing shortages and increased patient acuity, wages, working conditions, unsafe patient care due to nurses' workload, pay equity, autonomy, input into health care decision making, nurse health and safety, health care or staffing cuts, hospital overcrowding or "hallway medicine", and regionalization (MNU, 2003, p. 22; Mansell, 2004; McPherson, 2003). Between 1966 and 1982, there were 32 strikes by Canadian nurses (Mansell, 2004). The lengthiest strike by nurses in Canada (31 days) occurred in Manitoba when 9,500 nurses were on strike in 1991 for "improved wages, working conditions, job security, time off, pensions, benefits, and education" (MNU, 2003, p. 12; Mansell, 2004). In these instances, nurses communicated to renegotiate their relationship with the healthcare institutions, government, medicine, and the public.

While the history of nursing has paralleled the evolution of communication of nurses, the underlying assumption in the literature remains that if nursing students learn a defined set of behavioural nursing communication skills or techniques, they will be able to relate to clients in a caring and effectual manner (Hartrick, 1997) and speak as a member of the profession. Thus, the literature demonstrates that both individual nurses' voices and the emerging professional nursing body's voice have been subjugated by the political and social forces at the level of society or the public which includes physicians (at the systems level of the exosystem [Bronfenbrenner, 1979]) across historical course of events and environments of the first half of the 20th Century (at the systems level of the chronosystem).

To situate the concept of interpersonal communication of nurses within the contemporary literature, a discussion of communication in nursing must further explore (1) communication as a behaviour and (2) communication as relationship. The next two sections explore the influences

of theorists who have gained great attention in nursing and are most relevant to this study on interpersonal communication in nursing education specifically.

Communication as Behaviour

Medicine, psychiatry, and psychology have shaped nurses' understandings of communication. The objective in these fields has been primarily to *treat* clients using methods based upon the established paradigms of science and medicine that continue to dominate the social order of health care professions including nursing (Barker, 1998; Peplau, 1997). For example, many current approaches to nursing science and practice continue to use biological or pharmacological means of understanding clients. These approaches are linked to the promotion of "clinical effectiveness" and the ambition of "evidenced-based practice" that "favour the perceived 'gold standard' or randomized control trials and the virtue of quantifying human experience" (Barker, 1998, p. 215). As a consequence, communication is still commonly perceived to be a set of behaviours that the nurse performs in ways that can be known and observed (Hartrick, 1997); as such, communication is a task that the nurse *does* using a defined set of skills or techniques. The intention of the nurse is to resolve problems and meet the goals of care through the effective use of communication (Hartrick, 1997). The clear advantage of such an approach is that a definitive prescription is provided to nurses to perform communication skills appropriately and effectively. This section explores the behavioural views of communication that are included in the definition of interpersonal communication in this study.

The primary way that communication is viewed as a nursing behaviour is in the nursing profession's continued use of the term *therapeutic communication*. Therapeutic communication is used to describe the verbal and non-verbal communication skills nurses use to establish and maintain rapport, trust, respect, and empathy (CNA, 2008). This term is not new but rather was

coined by a psychiatrist, Jurgen Ruesch in his 1961 book, *Therapeutic communication*. Ruesch claimed that the nurse and client engage in a goal-oriented working partnership in the care of the client, and "therapeutically effective events" are "embedded in the process of communication" (1963, p. 132). Thus, the nurse is effective in his/her application of communication principles when he/she provides therapeutic environments that promote the health, well-being, and self-actualization of the client, as well as allow for negotiation of challenges in the health care setting (Arnold & Boggs, 2003; Gruber, 2007). A criticism of Ruesch's therapeutic communication is that the onus or responsibility is on the nurse to use a set of skills or tools to help the client achieve these ends. In other words, communication is something that the nurse *does to the client* who is expected to comply within this partnership. Using the lens of CST, it appears that therapeutic communication reinforces that a nurse's position of power, a relationship that is reproduced through nursing education championing therapeutic communication.

Nursing professional regulating bodies such as the CRNM (2008, 2013) and the contemporary nursing literature on communication (Berglund & Saltman, 2002; Gruber & Hartman, 2007; Maguire & Pitceathy, 2002) maintain that therapeutic communication tasks essential to nursing include: taking client histories using basic questioning techniques; interviewing clients using open-ended questions; giving information to clients; building and maintaining relationships with clients using techniques such as active listening and responding to verbal and non-verbal cues; tailoring information to the clients' needs and checking comprehension or clarifying information; collaborating with clients and members of the health care team; negotiating clients' ability/desire to participate in decision-making; discussing treatment options and implications; and relating to difficult individuals. In this view, barriers to effective communication have been identified as noise and other "blocking behaviour" such as,

offering advice and reassurance before the main problems have been identified, explaining away distress as normal, attending to physical aspects only, switching the topic, and "jollying" clients along by minimizing their concerns (Maguire & Pitceathly, 2002, p. 698).

This study incorporates the following aspects of the view of communication as a behaviour in nursing in this educator's definition of interpersonal communication in nursing: the face-to-face messages, in the form of oral words or language, the nonverbal body language and proxemics that nurses use to accomplish key nursing tasks, such as those described by Ruesch in this section. However, the definition of interpersonal communication in this study is not limited to behaviour, but rather includes aspects of communication as a relationship and partnership. Both communication as relationship and as partnership are at the level of the microsystem within EST as they imply the face-to-face roles and relationships of the nurse and the client with differing levels of intimacy or closeness between the nurse and client.

Communication as Relationship

Recent nursing literature links nurse-client communication to relationships and partnerships in care (Arnold & Boggs, 2003; Boscart, 2009; Doss et al., 2011; Gruber & Hartman, 2007; Peplau, 1997). The work of Peplau and more recent studies on nurse-client partnerships definitively connect communication and interpersonal relations or partnerships by claiming that the quality of the communication between the nurse and the client "[T]o a large extent, determines the caliber of the relationship" (Arnold & Boggs, 2003, p. 19; Henson, 1997; Henderson, 2003; Peplau, 1952). The proponents of relational practice, Hartrick Doane and Varcoe (1997) further this notion by claiming that a nurse's attitude and behaviour can create (or negate) a nurse-client relationship that has the potential to aid in healing. This subsequent section

explores the current nurse theorists' debate regarding nurse-client relationships and the nature of communication therein.

Hildegard Peplau, a psychiatric-mental health nurse, in her original work (1952) *Interpersonal relations in nursing*, was the first nurse theorist interpret the nurse-client relationship in terms of human contact as integral to the provision of nursing care (Peplau, 1997). Peplau's insightful shift in focus was from what nurses *do to clients* as part of medical treatment or care to what nurses *do with clients* (Arnold & Boggs, 2003). Her theory of nursing practice emphasizes the importance of the nurse-client relationship, an "interpersonal field" within which both the nurse and the client can experience personal and social growth/health and healing (Arnold & Boggs, 2003; Hart, 2010; Peplau, 1997). Therefore, relationships 'blur' the separate roles of nurse and client as they work in egalitarian partnership. In reality, the nurse has the power of the knowledge and skill to care for the ailing client, a fact that the theoretical lens of CST reminds me, the researcher, could not be ignored in this study.

Peplau's work focuses on three phases of nurse-client interaction and communication skills are linked to each of the three stages of the relationship: (a) an initial orientation phase (the nurse and client develop trust, provide and obtain basic information about the purpose, nature, and time available for the relationship. Non-verbal behaviours include smiling, handshaking, and making eye contact, for instance); (b) a working phase (the nurse and client clarify their expectations and ideas for care as well as the client's feelings, personal strengths/capacities, and potential resources. Problems are defined, goals are set at a pace that suits them, and an individual care plan is actualized with the client acting as a dependent, interdependent, or independent partner in care); and (c) termination (the nurse and client summarize the achievements of the relationship, and the loss of the relationship is recognized) (Peplau, 1988,

1997). Pelau's view of communication is included in the definition of interpersonal communication in this study. The specific behaviours (in the form of words and body language) create relationships aimed at completing specific nursing tasks. Moreover the relationship between the nurse and the client shape the interaction and maintain the nurse's power.

Unlike behavioural approaches to communication in nursing, the relationship between the nurse and the client is unscripted and not routine (Peplau, 1997, pp. 166-167). Peplau's work proposes that all persons differ from one another; therefore, interpersonal relations (as well as the communication necessary to effectively build, maintain, and terminate care in nursing) are as unique as the individuals in the nurse-client relationship. In interpersonal relationships, the nurse and client respect each other as individuals and as partners while working toward health goals for the client (Johnson & Weber, 2005). Therefore, the definition of interpersonal communication used in this study took into account Peplau's notion of relationships as shaping interactions during nurse-client communication.

Contrary to behaviourism and the biomedical model of health, Peplau's work acknowledges the art of nursing practice and is founded upon the values of nurses. Her work is part of a paradigm shift in nursing research and practice in the last two generations of nurses which values the concept of personhood (Arnold & Boggs, 2003), the working alliance between nurse and client (De Leeuw et al., 2012), person-centred care (McCance, McCormack, & Dewing, 2011), holistic approach to care (D'Amico et al., 2007) and whole person care (Joseph, Laughon, & Bogue, 2011). Furthermore, the adoption of qualitative research methods in nursing, more than any other discipline in health care, encompasses this paradigm shift that honors the clients' values, feelings, and lived experiences (Barker, 1998). As a result, nursing students who

learned to communicate in this study were seen as interacting with clients in a manner that is reflective of nursing as an independent academic and professional discipline in its own right.

Opponents of Peplau's work are commonly uncomfortable with the prospect of relating directly to clients without a script or set of instructions for communication. The insecurity and risk inherent in Peplau's theory may lead "nurses to employ 'models' of nurses (as opposed to theory) that provide them the security they desire: structures that will contain their interactions with patients" (Barker, 1998, p. 214). A further criticism of the theory of interpersonal relations in nursing is that Peplau is unclear as to the way in which nurse-client relationships develop into partnerships that promote health outcomes across varying social contexts and with diverse client health changes (Leenerts & Teel, 2006).

Relational nursing practice. Extending the work of Peplau, Hartrick Doane and Varcoe (2007, 2015), nurse theorists argue that an effective nurse-patient relationship necessitates that the nurse practice "caring attitudes and presencing behaviour" to create a connection between the nurse and patient that fosters/supports health and healing (p. 198). While Hartrick Doane and Varcoe focus on the importance of relationship in nursing practice similar to Peplau, they claim that nurses must use relationships as more than a means to the desired end of caring for the client or meeting the demands of the unit or facility. Moreover, these Canadian nurse theorists make unique contributions by arguing that the personal and contextual elements within relationship shape health and healing. Relational nursing practices are an important theoretical consideration in this study because if a nurse cannot communicate effectively, the implication is that this nurse will struggle to relate to others in caring and reflexive ways.

In essence, relational nursing practice is more personalized and more intimate than Peplau's theory of interpersonal relations. Nurses are encouraged to examine and work with their

clients' suffering and difficulty (as well as their own) as normal and natural outcomes that cannot always be treated or cured as in the biomedical model. The importance of the nurse-client relationship is emphasized in the promotion of healing, for each relationship is a site of opportunity to create a meaningful experience and response, no matter the health of the client or the complexity of the situation of care. They also draw a strong link between (a) a responsive, compassionate, and respectful nurse-client relationship and (b) the obligations of ethical and competent nursing practice. Healing and ethical nursing relationships are built within "a relational space" of the nurse-client relationship which is the product of their interactions, shared experiences, and their expectations for the present relationship in care (Hartrick Doane & Varcoe, 2007, p. 195). Hartrick Doane and Varcoe (2007) contribute the distinct notion that relational practice is a reflexive process that exists within socio-political, cultural, and historical contexts. Hence, relational practice influenced the definition of interpersonal communication in this study because the notion that relationships are shaped by personal and contextual elements forms the "interpersonal" in this definition.

While relational practice imparts a deeper level of healing by means of relationship that is created through communication, deciding if nursing responses are indeed healing and ethical within the relational space is a challenge, as the authors concede, because "the specific behaviours and responses are arrived at in the particularities of the relational moment-as we engage with and respond to, specific patients with particular situations" (Hartrick Doane & Varcoe, 2007, p. 195). At the outset of the study, I had wondered if nursing students who lack maturity or experience in practice would appreciate or be able to apply Hartrick Doane and Varcoe's relational nursing practice theory.

Nurse-client partnerships. Within the last decade, the nursing literature has explored the nurse-client partnerships as a co-creation that relinquishes nursing behaviours conveying power and control over the client (Henderson, 2003). From this stance, if the client is actively involved in the process of care and decision making, this individual is more likely to experience feelings of control, power, and empowerment, which in turn, improves health outcomes (Henderson, 2003; Krouse & Roberts, 1989; Leenerts & Teel, 2006). Consequently, the role of the nurse is to use communication to provide information and support that empowers the client to make decisions, choose and negotiate his or her own care, and form effective partnerships with health care providers (Doss et al., 2011; Henderson, 2003). In doing so, the nurse is to discover the client's unique needs and concentrate on building a partnership that addresses these needs (Henderson, 2003).

Within the nurse-client relationship, several factors traditionally give the nurse greater power or control over the client. The nurse is in a position of authority compared to clients who are ill and thereby vulnerable within the complex health care system (Henderson, 2003). Nurses commonly feel that they know what is best for the client and argue they should maintain their power and control over the situation when, in fact, clients are experts on their own lives (Doss et al., 2011; Henderson, 2003). Nursing students need to be made aware of the vulnerabilities of their clients and the extent to which their communication contributes to their clients' discomfort or ease, and whether their communication encourages the client to ask questions and advocate for the best care possible.

The nurse may use communication to facilitate or limit the partnership between the nurse and the client (Henson, 1997). The ways that nurses maintain control through communication are: limiting the depth and amount of conversation; persuading clients to cooperate; creating and

perpetuating uncertainty about the client's illness; failing to explain the processes of the complex health care system; providing only procedural information; using closed questions that only require 'yes' or 'no' responses; avoiding any disclosure about themselves to clients; perpetuating the belief that if a client is bothersome to the nurse, this client will receive poor quality care; limiting information; using phrases such as you must/you should/you have to; and using belittling language with clients such as 'dear', 'be a good girl', or 'my love' (Henderson, 2003, p. 507). Research on nurse-client partnerships is focused on the ways that this relationship shapes interactions of *power* during nursing practice, a notion that is included in the definition of interpersonal communication in this study.

Contemporary evidence on nurse-client partnerships views communication as an opportunity to create the connection and partnership with the client when it: conveys presence and promotes connection; encourages joint effort in achieving goals; reflects respect for each caregiver's uniqueness and humanness; and promotes cooperation in accessing resources (Henson, 1997, pp. 78-80). Leenerts and Teel (2006) argued that "communication that revealed the nurse's intention to be helpful, encouraged reciprocity and connection that created partnerships", and the four communication skills in their study that created "a relational conversation" included listening intently, affirming emotions, creating relational images such as focusing on the positive, and planning access to resources (pp. 471-472). When the nurse-client partnership is focused on the quality of life of the client, the nurse asks questions, listens, probes, listens more, and the empowered client asks questions, expresses concerns, requests information to make decisions, and voices an interest to understand his or her condition and treatment (Doss et al., 2011, p. 116). Therefore, the nurse-client partnership includes both the values of nurses and the specific communication directives for care. Helping a client to assume self-determination

and responsibility in the care one's own health occurs when the nurse and client develop equal power partnership in which the client is seen as an active and valued contributor (Bastable, 2008). This study built on this research by examining the ways that power played out through interpersonal communication in nurse-client interactions. As the next two sections describe, power is an integral part of interpersonal communication in nursing and nursing education.

Communication between Nurses: The Context of Nursing Practice Culture

Nursing practice is both cultural and contextual; a nursing student is shaped as a nurse by both the context of the particular units of NPRs and the culture of the nursing profession as a whole. Within EST, the macrosystem entails the influence of the culture on the individuals. In essence, nursing students are engaging in intercultural experiences as they recreate themselves as novice nurses within the relatively foreign culture of a particular unit and the health care system. Culture is reproduced during nursing education and socialization of nurses, at least in part, through their communication within roles and relationships. Moreover, their ability to receive positive or negative modeling and guidance on interpersonal communication is shaped by the culture of the nurses in the structural power relations on the unit of practice (Kohnke, 1981; Duffy, 1995; Farrell, 1997) as well as within the socio-historical moment in which nursing was practiced at the chronosystem level of the larger system. To engage with the phenomenon prior to data collection, I had to be cognizant of the contexts within which power is negotiated over time as nursing education has shifted from an apprenticeship model to a professional model, and briefly describes the embedded systems which created (1) the apprentice and (2) the present-day nursing student.

Historical Reflections: The Apprenticeship Model of Nursing Education

In Canadian nursing prior to the 1880s, nurses were family members or servants who were informally trained to care for the sick or dying primarily within private households (McPherson, 2004). Alternatively, religious orders were responsible for care, such as the Gray Nuns who established the first hospital in Western Canada, St. Boniface Hospital, during this period (St. Boniface Hospital, 2014). Hence, nursing practice originated in familial, religious, or servant roles.

As modern medicine developed in Canada, treatment within hospitals expanded, and administrators sought a new approach to staff the wards. Between 1875 and 1909, over 200 hospital training schools opened across Canada, including the Winnipeg General Hospital training program for nurses in 1887 (Bramadat & Chalmers, 1989). The apprenticeship of Canadian nursing students in hospitals served as the dominant system of nursing education from the turn of the century until the 1970s (Bramadat & Chalmers, 1989). In this apprenticeship system, single women laboured in hospital wards and lived in the nurses' residence for two to three years in exchange for their training and license as a nurse (McPherson, 2004). Apprentices were on duty six and a half days per week for 12-hour shifts and lived in nurse residence under strict rules and curfews although these working hours and residency became less necessary in the 1940s (McPherson, 2004). Apprentices laboured through a rigid schedule of nursing work that increased in difficulty and responsibility over time. Until the 1950s, nursing students were predominantly single White females from both rural and urban upbringings, and both apprentices and nurses were required to leave the nursing program once they married (McPherson, 2004).

Within the apprenticeship model, nurse educators and administrators chaperoned nursing students' behaviour at all times and took on a parental or paternal role. More specifically,

experienced nurses were not only responsible for teaching nurses' work, but also served as role models of Victorian ideals of feminine respectability, subservience, and piety (McPherson, 2004). Nurse educators emphasized the importance of "cleanliness, order, and morality" (McPherson, 2004). Until the 1950s, nursing students wore a dress and cap that reflected Catholic ideals of celibacy and sexual repression of femininity in order to protect nurses against any sexual advances from clients and doctors (Canadian Nursing History Collection, 2014). Upon completion of their education, new graduate nurses participated in elaborate graduation ceremonies that were modeled after wedding ceremonies (Canadian Nursing History Collection, 2014). The implication was that graduate nurses were married to their work by taking on the role of subordinate to the physician who made the decisions about the clients' care.

Hospital apprenticeship of nurses declined from the 1960s to the 1990s as college-based and university nursing programs expanded their size and scope; as ethnic diversity, married women, and men were welcomed into the profession; and as Canada's universal health care system changed the nature of nurses' work and demanded greater specialization within the profession (McPherson, 2004). What emerged from these changes was a model of nursing education known as the "professional model" in that students' experience standardized nursing education, registration, and licensure as they are inducted into nursing practice (Branadat & Chalmers, 1989).

Recent Influences: The Professional Model

In nursing education, the theoretical model that educators frequently turn to in the socialization and professional development of nursing students is Benner's (1984) Stages of Clinical Competence. Benner's Novice to Expert model (adapted from Dreyfus' Model of Skill Acquisition) described and explored the transition of novice nurses from explicit rule-governed

behaviours in nursing practice to Expert nurses who are intuitive and adaptive to nursing contexts (Benner, 1984).

In this study, nursing students potentially experienced varying degrees of progression through Benner's (1984) initial two Stages of Clinical Competence, Novice and Advanced Beginner given the limited time of their Nursing Practice Rotations. According to Benner (1984), the Novice has little to no background experience in the nursing situations in which he or she participates in nursing practice rotations, so the Novice commonly struggles to determine what is relevant and less relevant in clinical interactions. The Novice functions at the level of instruction, and this individual routinely has difficulty applying information from theory courses to clients on nursing practice rotations. The Advanced Beginner has preliminary experiences and knowledge of the care context and can demonstrate some acceptable care based on previous clinical experiences, but this nurse/nursing student is continues to be guided by rules and still requires a mentor or experienced nurse to assist in care situations such as setting priorities or integrating knowledge from theory courses (Benner, 1984). The nursing students in this study did not receive the two to three years that Benner saw as necessary for the nurse to reach the Competent stage of development in which the nurse can recognize patterns in the care of clients and can prioritize care.

Benner (1984) claimed that learners transition from one stage to the next through the combination of nursing knowledge and experience in the clinical setting. More importantly, Benner believes that nurses can be taught to advance through the stages through discussion and feedback between the nurse educator (or other nurses) and the learner (Novice or Advanced Beginner for example). Interestingly, Benner's work is contingent on a willingness and ability on the part of nurses to share their expertise and engage with nursing students in relationships and

interpersonal communication about nursing practice. Within contemporary nursing literature, nursing practice culture is directly and indirectly described in terms of virtues and power struggles which impact the nursing student's transition into the professional culture of nursing.

Unsurprisingly, nursing students continue to aspire to be good nurses. Literature examining perceptions of nurses (Catlett & Lovan, 2011; Smith & Godfrey, 2002) and clients' (Brady, 2009; Rchaidia, Dierckx de Casterle, De Blaeser, & Gastmans, 2009) perceptions of what constitutes "a good nurse" demonstrates that both nurses and clients describe the good nurse in the same ways. Good nurses are characterized by their: (a) personal characteristics, such as being kind, caring, compassionate, respectful (Brady, 2009; Catlett & Lovan, 2011; Rchaidia et al., 2009), selfless, honest, courageous, loyal, nonjudgmental, positive in attitude, possessing a sense of humour (Catlett & Lovan, 2011), cheerful, helpful, gentle, friendly, reassuring (Brady, 2009); (b) professional characteristics such as being patient centred, treating the patient as an individual (Rchaidia et al., 2009; Smith & Godfrey, 2002), self-controlled, self-motivated, responsible (Catlett & Lovan, 2011) and trustworthy (Brady, 2009); (c) knowledge in terms of competence and critical thinking (Brady, 2009; Rchaidia et al., 2009; Smith & Godrey, 2002); and (d) professional skills that include being efficient and multitasking, following policies, advocates for patients (Catlett & Lovan, 2011), communicating effectively and dressing appropriately to the role (Brady, 2009; Smith & Godfrey, 2002). Nurses further identified the good nurse as a good colleague who is "a team player, cheerful, not disgruntled, dedicated, committed, accountable, and treating other nurses well" including "remember[ing] what it is like to be a new graduate nurse and you know nurses need to treat other nurses well" (Catlett & Lovan, 2011, p. 59). In addition, professional codes such as the Nursing Code of Ethics (CNA, 2008) in Canada describe the detailed duties and ethical responsibilities of nurses. The

participants had learned about the Code in their third year of studies in the course "Introduction to Legal and Ethical Foundations of Nursing Practice" (see Table One: Undergraduate Nursing Curriculum on page 8). In light of these findings, the nursing student would anticipate a welcoming, caring, knowledgeable, environment within which to be mentored into the nursing profession.

In contrast, nurses and other health care professionals informally describe nursing practice culture as "nurses eat their young" (Bartholomew, 2006, p. 1). Through their nursing education in NPRs, nursing students consciously or unconsciously learn that communication in nursing also exists to negotiate potential imbalances and abuses of power (Lewis, 2006; Quine, 2001; Souza, 2012). Nursing students are exposed to and may experience the misuse of power among nurses in the "overt and covert non-physical hostility, such as, criticism, sabotage, undermining, infighting, scapegoating, and bickering" (Duffy, 1995, p. 16). More specifically, nursing students in NPRs may be exposed to communication among nurses that includes name calling, fault-finding, backstabbing, intimidation, gossiping, verbal abuse, condescension, humiliation, while documented covert behaviours encompass a failure to reply to emails or phone calls, ignoring, unrealistic deadlines or expectations, excessive monitoring of performance, sabotage by withholding information, or exclusion from nursing cliques (Bartholomew, 2006; Brown & Middaugh, 2009; Johnson, 2009; Rowe & Sherlock, 2005; Sousa, 2012). They may also interact with nurses whose communication includes raised eyebrows, snide remarks, sighing, turning away from a colleague, talking behind another's back, withholding information, gossip, screaming abuse, ceasing communication with another, and refusing to move out of someone's way (Brown & Middaugh, 2009; Johnson, 2009; Rowe & Sherlock, 2005; Sofield & Salmond, 2003). Nursing students may see or experience the well

documented physical effects (insomnia, digestive disturbances, headaches, fatigue), emotional effects (low self-esteem, anxiety, depression, lack of motivation), psychological effects (maladaptive responses such as substance abuse or overeating), and social effects (isolation, exclusion, strained personal relationships) of horizontal violence among professional nurses (Bartholomew, 2006; Brown & Middaugh, 2009; Johnson, 2009; Lally, 2009; Lewis, 2006; Rowe & Sherlock, 2005). As a result, the framework of CST was an ideal framework for examining the tensions or conflicts that develop between nurses, and between nursing students and nurses in the socialization of nursing students. The context of NPRs in this study includes the fact that nurses practice within a health care system in which they have limited power and nursing students are expected to 'fit in'. Understanding the professional realities of nurses was integral to framing and interpreting the study.

Numerous circumstances within the nursing profession have shaped this practice culture. First, nursing students are socialized into a nursing practice culture with a long history of limited power. Since the inception of nursing, nurses have lacked power within the hierarchy of the healthcare system (Farrell, 1997). Until the significant gains made the nurses unions in the 1970s to 1990s, generations of nurses had been thought of by health care institutions, provincial governments, and the public as "temporary employees who had marginal attachment to their jobs" as they would eventually leave nursing to become wives and mothers (MNU, 2003, p.10). As a result, working conditions for generations of nurses have remained such that nurses have lacked control over working environments and patient care concerns (Mansell, 2004), and administration has often ignored nurses' views (MNU, 2003).

Second, nurses have been subjected to varying forms of disrespect or aggression from the medical profession, as well as patients and their families during the course of stressful and

demanding work (Brown & Middaugh, 2009; Farrell, 1997; Johnson, 2009; Kuehn, 2010; Lally, 2009; Rowe & Sherlock, 2005). Violence against nurses is also reportedly common in Canada (Shields & Wilkins, 2009), the United Kingdom (Quine, 1999, 2001), and Australia (Farrell, 1997, 2001; Rutherford & Rissel, 2004). In Canada, Shields and Wilkins (2009) reported that 34% of Canadian nurses providing direct client care in hospitals or long-term care facilities had been physically assaulted by a client, and 47% had been emotionally abused by a client within the previous year. Some authors claim that this violence in health care settings is on the rise (Kuehn, 2010).

Third, challenging the dynamics of power implies challenging what it means to be a nurse. Sousa (2012) claims that nurses "... have been taught to be subservient and submissive, to do as we are told, to not make waves, to cope" (p. 29), so if a nurse were to voice his/her concerns against a more powerful administrator, physician, client, or nurse of higher standing or experience, he/she would violate the idealized image of a nurse as someone who is sympathetic, kind, compassionate, and caring (Marks as cited in Farrell, 2001, p. 27). Although this image of nurses is changing in contemporary society, nurses who feel unequipped to speak out against unfair or unkind treatment of themselves or others commonly respond by saying nothing, doing nothing, or engaging in unhealthy coping like drinking or taking medications (Cooper, Walker, Askew, Robinson, McNair, 2011; O'Connell et al., 2000; Myrick et al., 2006; Sofield & Salmond, 2003). After reading these sources, I initially questioned if nursing students were still subject to social and systemic pressures of the first generations of nurses.

It is well documented that, to release the tension, pain, or frustration due to their inability to fight back, some nurses have engaged in conflict with each other (Duffy, 1995; Cooper et al., 2011; Farrell, 2001; Myrick et al., 2006). Thus, learning to be a professional nurse is not only

about acquiring skills and knowledge, rather nurses learn to be part of "a hierarchy entrenched in practice... which perpetuates ongoing subservience" (Myrick et al., 2006, p. 4). For instance, nursing clique groups within the unit staff and the profession may communicate in the aforementioned ways to maintain the status quo (Lewis, 2006). Consequently, the settings in which nursing students practice their first clinical skills, have their first encounters with clients and other health care professions, and attempt to establish their first collegial relationships are all too commonly environments that teach unequal power relationships which are then reinforced through communication. According to CST, an integral lens for examining the power struggles in this context, for these coercive contexts are re-enacted and reproduced over generations.

Thus, nursing students in this study were asked to describe the culture of nursing or the units and the extent to which it shapes their interpersonal communication. Examining the lived experiences of nursing students' interpersonal communication within the context of the nursing profession must consider the nature of evolving power relationships of the nursing student in his or her transition into the culture of nursing.

Communication between Nurse Educators and Nursing Students on NPRs

Within the nursing literature, the two factors which most significantly shape and influence the interpersonal communication among nurse educators and their students are the intergenerational differences between the nurse and the student (Fater, 2010), and the integration of the student into the culture of the unit of the particular NPR (Lewis, 2006). Again, the research demonstrates that power and relationship are paramount aspects of interpersonal communication in the NPR which is another key reason for employing the CST framework in this study; interpersonal communication is not simply a behaviour, but rather must take into account the motivations, needs, and intentions of those interactions.

Intergenerational Differences

Nursing education and practice settings are multigenerational places of interpersonal communication. Within EST, the chronosystem signifies the historical moment in time in which individuals (nursing students) are engaged in the setting (nursing education). A generation signifies the values and priorities of those born within a particular timeframe. As nursing students embark on their education and socialization, they face challenges and opportunities that are unique to their generation. Within undergraduate nursing education, current students are most commonly of the Millennial Generation while the faculty and staff in nursing practice settings are predominantly Baby Boomers (Mitchell, 2012). The particular moment in history has influenced the ways in which nursing students communicate and learn with/from CEFs, Buddy Nurses, Course Leaders, and with clients. In the undergraduate nursing program in this study, the Registrar (personal communication, July 2nd, 2013) determined that, of the 222 newly admitted nursing students for the 2013 to 2014 academic year, only nine students were from Generation X (aged 34 to 44). Of the 213 millennial students admitted to nursing, 11 students were born between 1980 and 1984 (33-29 years old), 32 students were born between 1985 and 1989 (28 to 24), and *170 students* were born between 1990 and 1995 (23 to 18). Increasingly, non-traditional nursing students (also known as minority or diverse students in the literature) are entering nursing education, and the undergraduate nursing program in this study is no exception. A non-traditional student has one or more of the following characteristics: aged 25 years or older, commutes considerable distances to attend university, is enrolled part-time, is male, is a member of a cultural, ethnic, or racial minority, speaks English as an Additional Language, has dependent children, or has required remedial classes (such as the GED) prior to admission to university (Jeffreys as cited in Bednarz, Schim, & Doorenbos, 2010). This information has informed this

study's sample as I attempted to replicate the nursing student population in contemporary nursing education.

The majority of faculty members and staff nurses with whom nursing students will communicate in nursing education are Baby Boomers who were born between 1946 and 1964 (Skiba, 2005). The Canadian Association for Schools of Nursing (CASN) (2012) states that nearly 40% of permanent nursing faculty were 55 years or older in 2011. Similarly, it has been reported that, for every Canadian nurse under the age of 35, there are two nurses aged 50 years or older (Canadian Institute for Health Information [CIHI], 2012; Health Canada, 2006). In fact, Canada has more nurses aged 50 to 54 compared to any other age group (Health Canada, 2006), and the average nurse has 18 or more years of experience (CIHI, 2012). Historically, the majority of nursing students have been young unmarried White women who entered nursing education shortly after completing high school (Pringle, Green, & Johnson, 2004), and the present generation of experienced nurses, Baby Boomers in particular, reflects this profile. This Boomer generation is known for their solid work ethic, sense of competition, and valuing respect for authority (Mitchell, 2012). Faculty Baby Boomers learned to develop the capacity for contemplation, critical reflection, scholarly expression, and to discern quality scholarship within the multitudes of information available today (Pardue & Morgan, 2008).

Baby Boomer nurses and scholars recognize their experiences of intergenerational differences because the characteristics of the Millennial Generation that are extensively reported in the nursing education literature. Scholars (Fater, 2010; Lower, 2008; McCurry & Martins, 2010; Mitchell, 2012; Pardue & Morgan, 2008; Revell & McCurry, 2010; Skiba, 2005; Strang, Bagnardi, & Williams, 2010) claim that millennial nursing students are: technological savvy; multi-taskers; global and multicultural; sheltered, special/unique and indulged by their parents;

confident, high achievers; team oriented; highly structured; and requiring frequent positive individualized feedback. McCurry and Martins (2010) claim that millennial generation students are uncomfortable with being critiqued and avoid engaging in debate, but rather prefer active learning, cooperative group activities, and study groups (Pettigrew, Kienger, & O'Brian King, 2011; Revell & McCurry, 2010; Skiba, 2005; Strang et al., 2010). Because the vast majority of nursing education research on millennial nursing students is conducted by Boomer faculty and Boomer nurse managers, this literature has a tone of shock and horror. The current understanding of millennial nursing students lacks commentary, quotes, or the voices of this generation. I found only one article written by a nursing student of the Millennial generation (Lower, 2008). As such, a case exemplar of a millennial nursing student and the subsequent implications for communication (written by myself, yet grounded in research) is helpful to the reader's understanding of generational differences in communication and learning in nursing education.

Within a NPRs, the Millennial student has greater orientation needs in comparison to previous generations of nursing students because the Millennial Generation individual feels safest in a highly structured schedule with clear expectations, similar to those set by parents, teachers, and after school activities of his or her youth (Lower, 2008; Pardue & Morgan, 2008). Clinical nurse educators must clearly and effectively communicate to this student: the starting, ending, and break times within the clinical day; how to dress and act professionally with regards to body piercings, tattoos, multi-coloured hair; and when it is appropriate to joke around and have fun with colleagues and when it is not (Lower, 2008). Because Millennial Generation children were so often raised in highly protective environments, the nursing student from this cohort in all probability may have had limited contact with individuals experiencing illness, pain,

disability, aging, or death, and consequently little understanding of the impact of these realities on the patient and the family (Fater, 2010; Heise, Johnsen, Himes, & Wing, 2012).

Consequently, a nursing student from this generational cohort requires coaching, guidance, and support in communicating with clients and families under stress or in distress. However, this student's clinical nurse educators also discover that the experienced staff nurses on the ward or unit become frustrated when this student finds the bedside health care technology to be non-user friendly, wants to take part in decision making, requests a schedule that accommodates his or her personal life, and sets unrealistic goals before the student has paid his or her dues in the profession (Heise et al., 2012; Lower, 2008; Pettigrew et al., 2011). In comparison, from the perspective of the Millennial student, such personally centred engagement would be seen as taking initiative and being collaborative with colleagues (Skiba, 2005). Achievement and success are highly important to Millennial cohort students (Pettigrew et al., 2011). Clinical nurse educators need to understand not only the power dynamics in the communicative structuring of nursing, but also the effects of the unique nature of generational cohorts not merely as idiosyncratic aberrations but as products of their experience if they are to bridge the differences in expectations across generations of nurses, and set each student up for success in nursing education.

The next section will demonstrate that differences in expectation between students and clinical nurse educators and other nurses is not being effectively bridged as aggression and miscommunication between nurses and nursing students occurs and reproduces inequitable power relationships across generations of nurses.

Fitting In

Student-nurses are especially vulnerable in the new hierarchy of the NPR because they are insecure in their roles and knowledge, and their collegial relationships are new (Sousa, 2012). Nursing students in Curtis et al. (2007) study spoke of a "pecking order" in the clinical unit wherein staff nurses treated the nursing students and newly graduated nurses poorly (p.160). Clinical educators who do not work on the unit upon which they teach may also have to fall in line. Staff nurses may not be directly involved in the student's learning, but the staff nurses' attitudes and behaviours, and the culture of the unit can "set the tone" for nurse educators' interactions with/responses to the nursing students (Myrick et al., 2006, p. 7). Thus, nursing students learn the "culture of power" in which power is used to maintain the status quo among the nurses. Clinical educators could use (or share) the experience as a means to teach the culture of the unit in a way that supports the student and disrupts the power relations. CST was used as a lens in this study to examine the engrained power struggles that are reproduced during the socialization of nurses. In the words of Foucault, a thinker at the foundation of CST, "those disciplining and those disciplined are caught in self-reproducing relations of power" (Garnsey, 1993, p. 240).

Nursing students who experience aggression from nurse educators or unit staff feel powerless (Curtis, Bowen, & Reid, 2007) are in a double bind in which "We can't say much or we'll get kicked out for being disrespectful" (Cooper et al., 2011, p. 10) or may "jeopardize our ability to successfully complete the program" (Myrick et al., 2006, p. 9). The students are caught in a power struggle that they are sure to lose, for too much is at stake if they attempt to confront the aforementioned behaviour from nurse educators or staff nurses (Kolanko et al., 2006). Thus, nursing students used phrases like "don't rock the boat" or "keep a low profile" (Levett-Jones &

Lathlean, 2009, p. 344, 346), "stay under the radar" (Myrick et al., 2006, p. 9), or "develop a thick skin" (Curtis et al., 2007, p. 160) to describe their survival strategies on NPRs. Other students rationalised or excused behaviours of the nursing staff and did not attempt to challenge them because "it was seen as upsetting the status quo" (Levett-Jones & Lathlean, 2009, p. 344). Therefore, students' communication was a reflection of their status.

Nonetheless, the literature is clear that nursing students have a drive to "belong" and be accepted in nursing practice environments by their educators, the unit staff, and the other nursing students (Bradbury-Jones, Sambrook, & Irvine, 2011; Cooper & Curzio, 2012; Cooper, Walker, Winters, Williams, Askew, & Robinson, 2009; Levett-Jones & Lathlean, 2008; Levett-Jones, Lathlean, Maguire, & McMillan, 2007; Roberts, 2009). Belonging or the development of the nursing identity that they are constructing is what the drive helps to create. *Fitting in* constitutes belonging, being a nurse and learning to practice from a particular standpoint or position using all the knowledge and authority to achieve such. An *inability to fit in* a nursing practice setting negatively impacts a nursing student's: willingness to conform to and condone inappropriate nursing behaviours and health care practices on the unit, as well as impacts the student's motivation to learn, act independently, anxiety, and confidence to ask questions (Levett-Jones & Lathlean, 2008; Levett-Jones et al., 2007). Negative experiences of learning how to fit in impairs nursing students' abilities to communicate effectively, particularly when they reported feeling: useless, inadequate, belittled, overwhelmed by the realities of the clinical context, like they were getting in the way, unaccepted by staff, ignored, disregarded or disrespected by preceptors during clinical practice (Bradbury-Jones et al., 2011; Chesser-Smyth, 2005; Rush, McCracken, & Talley, 2009; Watkins, Roos, & Van der Wald, 2011). When preceptors and other nursing staff fail to show encouragement, interest, or respect for nursing students, but rather make "little

attempt to hide their impatience and frustration", nursing students lack the confidence to communicate effectively with nurses and clients (Bradbury-Jones et al., 2011, p. 371; Chesser-Smyth, 2005; Chesser-Smyth & Long, 2013).

When students were given opportunities to use their skills, be responsible, and make a difference, they felt empowered (Bradbury-Jones et al., 2011). No matter the clinical context (gerontology, pediatrics, perioperative, community, palliative care) of the NPR, nursing students wanted and needed guidance from their nurse educators in the form of effective professional relationship (Callagan, 2011; Foley et al., 2012; Kohn & Truglio-Londrigan, 2007; Magnussen Ironside, 1999; Papp et al., 2003; Sorrell & Redmond, 1997; Wright & Wray, 2012). Students "highly valued" a receptive welcome to the ward environment (defined by an educator's respectful, accepting attitude) and claimed that this welcome had a positive impact on their self-esteem (Chesser-Smyth, 2005, p. 323; Melincavage, 2011). Moreover, the nurse educator's manner, conduct, mutual respect, and desire to get to know the student as a person were cited as aspects of interpersonal chemistry or caring that made students feel safe and enhanced their learning by giving them the confidence to: ask questions, immerse themselves in the environment, use their intuition, think like a nurse (critical thinking), and engage with other health care providers (Callagan, 2011; James & Chapman, 2010; Pedersen & Sivonen, 2012; Magnussen Ironside, 1999; Sorrell & Redmond, 1996; Thorkildsen & Räholm, 2010). Students' confidence increased when they were listened to, and encouraged to engage in and master new skills (Baglin & Rugg, 2010; Pedersen & Sivonen, 2012), or they were given opportunities "to do real nursing", be responsible for caring for others, or solve problems in care (James & Chapman, 2010, p. 41; Magnussen Ironside, 1999; Thorkilsen & Räholm, 2010). By providing comfort and care to patients they felt "worthy, valued, and that they had made a difference"

(James & Chapman, 2010, p. 41). For example, one nursing student expressed, "My mentor allowed me to visit a patient who I have cared for over the last five weeks under observation, on my own this week. I felt really good that a patient and the team trusted me enough to carry out the planned care independently" (Baglin & Rugg, 2010, p.149). Thus, nurse educators who developed relationships with students allowed the students to feel like part of the health care team, which in turn gave students the confidence to communicate with staff and patients (Baglin & Rugg, 2010; James & Chapman, 2010; Papp et al., 2003; Sorrell & Redmond, 1997). According to EST, an individual will thrive within the microsystem of direct relationships with "significant people" who are "more mature and experienced individuals" (Bronfenbrenner, 1979, p. 212). In this way, nursing students thrive when nurses were valued, respected, and given responsibilities as a member of the team.

Students who felt unwanted or unappreciated by the nurse educator or other members of the health care team had poorer clinical experiences, weaker confidence in their clinical abilities, and less effective communication (Chesser-Smyth, 2005; Foley et al., 2012; Kohn & Truglio-Londrigan, 2007; Melincavage, 2011; Papp et al., 2003; Wright & Wray, 2012). These students viewed faculty, staff nurses, and other health care providers as authority figures who had power and influence over them (Melincavage, 2011), "check[ed] up on them", ignored them (Magnussen Ironside, 1999, p. 329), were inconsiderate of students' inexperience, demeaned them by calling them names, yelled at them, and failed them in the NPR in front of other students or health care providers (Foley et al., 2012; Melincavage, 2011). Justin, a student in Foley et al. (2012) claimed that some older clinical nurse educators have preconceived ideas about their generation of nursing students which negatively affects these students:

We go into clinical and we're really nervous and we're there to learn, we want to do the

> hands on stuff, that's our opportunity to learn it, and they already have it in their minds that we don't have a clue...and it frightens us, and then, we're like 'well maybe we CAN'T do it'. Even though we know in our minds the steps to do a skill, we question ourselves. (p. 3)

Under these conditions, nursing students felt that they "learned nothing" on the NPR (Magnussen Ironside, 1999, p. 240). Moreover, their communication and learning are impacted because when students felt they were a burden, they kept their distance from their nurse educators, refrained from asking questions, did not seek advice, were more likely to be fearful of conducting procedures or harming the client, and appeared disinterested or lacking initiative (James & Chapman, 2010; Thorkildsen & Räholm, 2010). Therefore, professional growth is stunted when students are seen and but not heard. What is interesting about the contemporary literature is that scholars report on nursing students' interactions with nurse educators or staff nurses. This study explored the interpersonal communication between nursing students and their CEFs, Buddy Nurses, Preceptors, and Course Leaders, specifically.

Nursing Students' Communication with Clients on NPRs

The nursing literature on nursing students' communication with clients on NPRs is examined at the systems level of the microsystem, the nursing student's face-to-face relationships with clients that shape the student's role within the NPR. It has been established that nursing students consistently reported feeling overwhelmed by the range of nursing skills, knowledge, and interpersonal communication necessary to practice the nursing role (Callagan, 2011; Chesser-Smyth, 2005; Foley et al., 2012; James & Chapman, 2010; Melincavage, 2011; Pedersen & Sivonen, 2012; Reese, 2013; Rohde, 1996). Representative comments from nursing students include, "I think initially, it was very confronting seeing such acutely sick people and

they were very sick...so that knocked me on my feet, my reaction to seeing sick people" (James & Chapman, 2010, p. 40), and "I see how she [the clinical educator] asks questions, how she interacts with the patient...How to work, what to prioritize, how to make the situation flow. How does she manage things?" (Thorkildsen & Räholm, 2010, p. 186).

However, nursing students revealed that they not only learned to acquire skills (such as doing blood tests, drug administration, or inserting urinary catheters), competence in practice, or an understanding of policies, procedures, and resources (Baglin & Rugg, 2010; Holström & Larsson, 2005; Melincavage, 2011; Wright & Wray, 2012), they learned the importance of patient vulnerability, dignity, and privacy, and to communicate with patients who were in pain, suffering, or dying (Callagan, 2011; Fagerberg & Ekman, 1997; Gunby, 1996; Loftus, 1998; Sorrell & Redmond, 1997). As a result, the students learned to refer to their patients *as people*, not by their diagnoses (Holström & Larsson, 2005; James & Chapman, 2010; Papp et al., 2003; Rohde, 1996; Thorkildsen & Räholm, 2010). In other words, while a student might have initially referred to "helpless old patients", "the lady with Hep C", or the mentally ill, in getting to know the patient, in observing the ways in which the patients attempted to cope with illness, or in receiving gratitude from the patients, nursing students changed their perceptions (Fragerberg & Ekman, 1997, p. 185; James & Chapman, 2010, p. 41; Rhode, 1996). Nursing students who forged meaningful relationships with clients aimed to provide them holistic care (not only physical care, but care that recognizes the emotional, socio-cultural, spiritual, relational, and contextual aspects of the patient's experience of illness) (American Holistic Nurses Association, 2013; Holmström & Larsson, 2005; James & Chapman, 2010; Papp et al., 2003). Importantly, it was through conversation and authentic dialogue with clients that nursing students became receptive to their clients' experiences to the extent that students reframed and transformed their

relationships with clients (Rhode, 1996). The nursing students learned the importance of allowing time to listen to the patient and consider their therapeutic responses prior to communication (Holström & Larsson, 2005). Thus, nursing students' new perceptions of the clients shaped their approach to communication.

Lived Experiences of Nursing Students' Communication on NPRs

The phenomenological research indicates that nursing students feel vulnerable during their NPRs when "thrust into a world of pain, intimacy, doubt, and confusion" (Sorrell & Redmond, 1997, p. 232). Essentially, most nursing students are inadequately prepared emotionally for the challenge of nursing clinical practice (Gunby, 1996; Loftus, 1998). Multiple studies demonstrate that, to a greater or lesser degree, nursing students absorb, internalize, or identify with their clients' pain, fear, distress, suffering, frustration, or anger (Eifried, 2003; Fagerberg & Ekman, 1997; Gunby, 1996; Loftus, 1998; Pederson & Sivonen, 2012; Rees, 2013; Rohde, 1996; Sorrell & Redmond, 1997). In caring for clients who were mentally or physically ill or injured, terminally ill, suffering, or who suddenly died, nursing students reportedly: brooded about a client incident and relived it for days; had psychological signs of distress such as sleeplessness, a rash, shakiness, numbness, and crying; feared that they would cause suffering to the client; lost their own dignity through over involvement with the client; and felt shock, disbelief, anger, sadness, fear, guilt, horror, loss, let down, isolation, a nervous wreck, powerlessness, and emotionally drained (Eifried, 2003; Gunby, 1996; Loftus, 1998; Pederson & Sivonen, 2012; Rees, 2013; Rohde, 1996).

One concerning theme within the phenomenological research is that many nursing students expected their clients to get better and saw their role as helping them recover; they were unprepared for the fact that many of their patients would die (Loftus, 1998). For instance, a

student in Loftus (1998), Mary, returned to her clinical practice from days off and found her client had deteriorated. Mary felt angry and let down:

> I was really shocked at how she was. I did feel angry at this. I felt terrible afterward I didn't realise at the time how seriously ill she [the client] was. I felt at times, really angry because she seemed to give up. She didn't seem to want to go on any more and I couldn't understand her. I could understand her being depressed but I didn't understand why she didn't want to try. I didn't realize she was so ill. I'd seen other patients who look not well but they got better. (645)

Mary's comments are consistent with the findings of Fater (2010) and Heise, Himes, and Wing (2012) who claimed that the present generation nursing students have been sheltered from the natural processes of aging, illness, pain, suffering, or death. Consequently, it appears that current nursing students need be taught that aging and death are natural anticipated processes in the lifespan of humans, about which one can openly communicate.

Another concern in the research is that nursing students, who lack the knowledge and experience to understand the clients' physical conditions and resulting emotional manifestations, are also at risk for developing a selfish attached love for their clients (Fagerberg & Ekman, 1997). For example, a student reported, "I'd like to stay with the patient [i.e.: client] all the time [takes a deep breath]. But it's just...to make the patient feel safe and sure that there's someone there with him at the end. But it's not just that I wanted the patient [client] to have this feeling. It was for my own sake. So I would feel better" (Pederson & Sivonen, 2012, p. 841). Another student "who cared very deeply for her patients [clients] and felt totally and personally responsible for them, prayed that her 90-year old terminally ill client would not die on her shift because then it would be 'her fault'" (Sorrell & Redmond, 1997). The reason for this attachment

may be that present nursing students frequently place high demands on themselves and find it hard to forgive themselves if they make a mistake or feel they have let clients down (Eifried, 2003; Sorrell & Redmond,1997), which is consistent with research on Millennial nursing students (Lower, 2008; Strang et al., 2010). As a result of these unrealistic expectations for themselves, students may focus on their own feelings rather than those of their clients; in this way, their vulnerability is a weakness and a liability in care (Pederson & Sivonen, 2012).

Other key themes in the phenomenological research on nursing students were related to students' unfamiliarity with the emotional nature of providing holistic care, facing ethical dilemmas, and the triggering of their own personal memories. To illustrate, many of the male students in Strubert's (1994) study described holistic care as unfamiliar or foreign to them, "...being so close to them [the clients], sharing everything. Being there when they cry, when they die, when they need to vomit or relieve themselves. This is not something men are used to" (p. 30). For some students, their personal morals, values, and beliefs were challenged in the care of a client (Rees, 2013; Rohde, 1996). Dawn, a nursing student and a devout Catholic, became distressed when caring for a client who terminated her pregnancy (Rees, 2013) while Emma, a student caring for an elderly female client, was upset that the nurses treated her client as if she were bothersome or a nuisance (Fagerberg & Ekman, 1997). Other nursing students experienced a triggering of past events from their own lives, such as the memory of a loved one or an illness within one's own family (Fagerberg & Ekman, 1997; Kohn & Truglio-Londrigan, 2007; Rohde, 1996). While these findings further support the notion that students lack of preparedness for nursing practice, it also appears that nursing students in this generation need to learn to prioritize the clients' needs above their own needs. Educators facilitate this process by teaching the students communication skills that build a therapeutic relationship between the student and the

client that is focused on the care of the patient. The challenge for educators lies in the fact that present Western societies and popular culture have taught students to view themselves "as consumers who want to learn only what they have to learn" in a way "that is best for them" (Sweeney as cited in Skiba, 2005, p. 370).

Nonetheless, phenomenological researchers consistently reported that the ability of nursing students to manage their overwhelm, fear, and socialization to the clinical context largely depended on the mentorship that students received from clinical educators and staff (Eifried, 2003; Loftus, 1998; Kostovich & Thurn, 2013; Melincavage, 2011; Sorrell & Redmond, 1997). Nurse educators and other health care professionals who shared their own fears, past mistakes, and learning "empower[ed] students and enfold[ed] them in a caring community of nursing" (Sorrell & Redmond, 1997, p. 233). Nursing staff who sent students away for break after a particularly challenging moment in care or who failed to mention an emotionally demanding client event ever again did not help the students manage their emotions (Loftus, 1998); it was the educators and staff who told students that it was okay to cry who were helpful (Efried, 2003; Sorrell & Redmond, 1997). In fact, educators who facilitated self-reflection in their students helped them transform their perceptions and misunderstandings though dialogue, and the emotional load on the nursing student was reduced as a result (Rees, 2013; Rohde, 1996). For vulnerability to become a source of personal development for a nursing student, it is clear in this research that the nurse educator must guide the student in professionalism, and encourage courage and compassion (Pederson & Sivonen, 2012). Moreover, effective mentoring from nurse educators taught students that "we should communicate with each other. We should all work together. It is important to communicate and respect everyone's opinion even if you don't agree with them" (a student in Kostovich & Thurn, 2013). As such, acquiring effective communication

skills to enable coping during difficult moments in care is integral to the long term health and well-being of the student and future professional nurse.

Lastly, the phenomenological scholars in nursing education also warn their readers that, in the absence of appropriate support, students' inability to manage their emotions and maintain a professional approach to care meant some nursing students became disengaged or disembodied within NPRs (Rees, 2013). In other words, these students felt the need to protect themselves by distancing themselves from the client (Gunby, 1996) which is not conducive to providing therapeutic communication. Within the research, these students described their pride in being capable of hiding their emotions within the clinical setting (Rees, 2013). Paterson et al. (1996) and Streubert (1994) argue that male nursing students are far better at concealing their feelings during NPRs. Some of these students sought comfort and debriefed about their experiences in NPRs with fellow students or friends and family when support was unavailable from their educators (Loftus, 1998; Kovovich & Thurn, 2013). While family, friends, and fellow of students may validate their experiences and provide some measure of comfort, these individuals lack the knowledge and experience of nurse educators and staff that have their own lived experiences of care and who are, at least to some degree, trained in counselling and therapeutic communication skills.

Summary

The literature gathered and carefully considered in this chapter has clarified and broadened my prior understandings of the lived experiences of nursing students' interpersonal communication in NPRs. Before exploring this literature, I had a somewhat superficial view of nursing student's experiences because I did not have a sense of the evolution of nursing and the structure of power within which nurses practice, nor did I understand the extent to which nursing

students are vulnerable as they enter these larger systems of nursing practice in their clinical practice rotations. I carried this appreciation of the structures within which nursing clinical education occurs into the data collection and remained cognizant of which lived experiences and perceptions belonged to the students and which perceptions were my own.

In this chapter, I engaged with five categories of literature necessary to my understanding of the lived experiences of interpersonal communication by nursing students. First, I explored the historical and contemporary literature on nursing communication as nurses found their voices as a profession and distinct professional discipline. Second, I examined the research on communication among professional nurses in nursing practice settings to shed light on the way in which power relationships are reproduced between nurses. Third, I reviewed the literature on communication between nurse educators and their students on NPRs which shows that generational characteristics of students and their ability to fit in on the NPR shapes their communication with nurses and clients. Next, I looked at communication between nursing students and their clients (Callagan, 2011; Fagerberg & Ekman, 1997; Holström & Larsson, 2005) as this research demonstrates that students commonly lack emotional preparedness for NPR which influences their efforts to communicate and sustain relationships with their clients. Lastly, I found that phenomenological studies directly related to nursing students' lived experiences on NPR (Eifried, 2003; Pederson & Sivonen, 2012; Rees, 2013) have reiterated the importance of relationships, roles, and status in nursing education from the point of view of the nursing students.

Links to EST and CST Theoretical Frameworks

The table below summarizes the ways that Ecological Systems Theory (EST) and Critical Systems Theory (CST) have been linked to the existing literature in this chapter on nursing

communication. At first glance, one notices the limited information about nursing student's relationships, roles, and status relative to the Buddy Nurses (staff nurses), Course Leaders, or Preceptors within NPRs. This study has addressed this gap in our understanding of nursing students and other nurses on the NPR who are not the student's the immediate CEF. Notably, the literature has extensively explored the relationships between nurses and other significant face-to-face persons within the microsystem. Within the exosystem, this study built upon the policies, procedures and expectations of the Faculty of Nursing of nursing education and the *Standards of Practice* set by the College of Registered Nurses of Manitoba (2007). While the macrosystem has been explored in a substantive body of work on the culture of nurses, I was interested in how nursing students experienced that culture as part of their NPRs. The chronosystem in this study considered the influence of the nursing students' generation and that of their nurse educators on NPRs as part of this study. Lastly, CST in the nursing literature in this chapter was largely confided to the dominance of the medical community and the healthcare system towards nurses. In contrast, this study has focused on the ways in which power is negotiated among nurses and their nursing students.

Table III: Nursing Education Literature and EST & CST

	EST: microsystem	**EST: mesosystem**	**EST: exosystem**	**EST: macrosystem**	**EST: chronosystem**	**CST**
Nursing Education Literature	Physician & nurse Nurse & client Nurse & nursing student Nursing student & client Relational nursing practice & Partnerships	Limited information about Buddy Nurse & nursing student	Policies, procedures and expectations of: Nursing profession Nursing education Nurse Unions	Beliefs and ideology of: Medical community The public or society about nurses Health care system Culture of nurses	Influence of the time in terms of: Religious orders Advances in science War Generations of nurses	Coercive contexts: Dominance of medicine Health care system & use of nursing labour Nursing education Horizontal violence between nurses Therapeutic communication

CHAPTER THREE: METHODOLOGY AND METHODS

The purpose of this study is to explore the lived experiences of nursing students who communicate interpersonally with nurses and clients as part of providing care during Nursing Practice Rotation (NPR)s. This chapter describes the theoretical orientation and the methodology of this study in terms of the researcher's decision to conduct qualitative research, the choice of phenomenology, and the use of the hermeneutic phenomenological research methodology. The latter section of this chapter will outline the specific research methods of this study therein.

Qualitative Research

Researchers who wish to deeply understand the complexities of human behaviour, turn to qualitative research to answer questions that cannot be understood through the objective, fixed, value-free means and beliefs of quantitative research. In choosing to undergo a qualitative inquiry, the researcher formulates a point of view within the five philosophical assumptions of qualitative research: the nature of reality (ontological), the relationship between the researcher and the researched (epistemological), the positioning of the researcher within the research (axiological), and the language used in the research (rhetorical), and the process of research (methodology) (Creswell, 2007). Therefore, my stance on each of the five qualitative research assumptions had practical implications for my study design and the way in which I carried out the research as explained in this chapter.

Qualitative research was the most suitable choice of inquiry for this study because neither the process of qualitative research nor its outcomes are "simplistic and simple", just as the experiences of being a nurse or a client within the Canadian health care system are rarely straightforward and free of miscommunication (Morse, 2003, p. 834). As I am interested in communication within the complex power structures of nurse-client and nurse-nurse

relationships, qualitative research was the most appropriate choice because it is used when "we need a complex detailed understanding of the issue" (Creswell, 2007, p. 40).

Qualitative research was most useful for this study because I explored the human dilemmas and experiences of individuals whose voices are not often heard in society, or in this case, the nursing profession (Creswell, 2007). Within the ranks of nurses, the nursing student has limited autonomy or independence, and is relatively powerless within the challenging practice culture of nursing. The inductive nature of qualitative inquiry implies that the lived experiences, responses, thoughts, and feelings of the nursing students are important and worthy of study (Creswell, 2007). I have interpreted the nursing students' valuable experiences and stories of interpersonal communication in terms of the meanings that the student nurses brought to them (Denzin & Lincoln, 2005).

Qualitative research is necessary for this study because I wanted to achieve a holistic account of the meanings of the nursing student participants which requires: an openness to the research process as it unfolds over time (Guerin & Guerin, 2007), an emergent and flexible research design, and a dynamic research process (Creswell, 2007; Frankel & Devers, 2000). Thus, I had to be receptive to new ideas and open to different ways of being, surviving, and thriving in interpersonal communication within the contexts of NPRs (Carspecken, 1996). In undergoing this qualitative research study, I had anticipated that both the students and I would learn about communication in NPRs in the process of the doing research (Bradbury-Jones, Irvine, & Sambrook, 2011; Eide & Kahn, 2008).

Finally, I value that qualitative research allows for the experiences, stories, and the voices of the nursing students to be communicated in the findings 'as they are', not as I 'translate' them into academic rhetoric. Consequently, I have attempted to disseminate my research findings in a

style, tone, and language that is accessible to the nursing student participants and non-academic audiences (hooks, 1992). Therefore, given the nature of the topic of the study and my values, qualitative research was the most appropriate form of inquiry for this study.

Epistemological Basis

Qualitative researchers shape their studies through their viewpoints on the five philosophical assumptions. The researcher's paradigm or worldview (post positivism, constructivism, participatory, or pragmatism) also informs a qualitative inquiry. While a discussion of the varying paradigms of qualitative inquiry is beyond the scope of this chapter, it is important to note that constructivism frequently informs phenomenology, the qualitative approach to this study (Creswell, 2007). Within constructivism, the purpose of research is to gather participants' perspectives in context, and interpret these viewpoints while recognizing that the researcher's own background shapes this interpretation (Creswell, 2007). Phenomenologists who ask study participants to describe their lived experiences, likely maintain a constructionist worldview because the focus of constructivism is the subjective meanings of individuals within their social and historical context, in this case, the NPRs of undergraduate nursing education in a mid-sized Canadian prairie province's health care system.

Phenomenology is an approach to qualitative inquiry rooted in the Western European philosophical movement of phenomenology in the 20th century that explored the "nature of experience from the point of view of the person experiencing the phenomenon" (Connelly, 2010, p. 127). Phenomenologist researchers tend to: oppose positivism, the worldview which arises from natural science and technology; believe that consciousness and the content of conscious experience (thoughts or emotions, for example) can be made evident and known; attempt to learn the ways in which individuals live an experience through their senses or physical bodies; describe the phenomenon prior to explaining it; and debate if separating the researcher's

background or interpretation from the research data is possible or useful (Centre for Advanced Research in Phenomenology, 2012). Hermeneutical phenomenology (van Manen, 1990) and transcendental phenomenology (Moustakas, 1994) are two of the most common approaches to phenomenology in qualitative research. Phenomenology is commonly used as a research method in the fields of Nursing and Education, for this form of qualitative inquiry values the experiences of "the whole person" (Balls as cited in Connelly, 2010, p. 127).

In this study, phenomenology was used to explore the essence of the phenomenon of nursing students' interpersonal communication in NPRs with nurses and clients. The goal of this phenomenology has been to "reduce individual experiences within a phenomenon to a description of the universal essence" (van Manen, 1990, p. 177). Moreover, in phenomenology, the researcher uncovers the meanings of lived experiences from the very individuals who are living (or have lived) the phenomenon (Creswell, 2007; van Manen, 1990). Therefore, I investigated the lived experiences of nursing students who had communicated interpersonally in NPRs (i.e.: who have had these lived experiences).

Through the interpretation of texts, such as interview data, the researcher then writes a description that returns to the phenomenon under study, which is known in phenomenology as reflexivity (van Manen, 1990). In other words, I interpreted the nursing students' individual lived experiences and created a description of what it means for these nursing students to communicate interpersonally in NPR with nurses and clients in order to answer the question: what is the essence of this experience? If done in accordance with the principles of phenomenology, my description has reflected the essence of the phenomenon to the extent that the students recognized their own experiences in the description.

For this study, I chose the specific hermeneutic phenomenological approach of Canadian phenomenologist Max van Manen because he has developed practical and skillful methodology for investigating the lived experiences of individuals. Max van Manen combines descriptive and interpretive phenomenology in that he claims all phenomenological descriptions are interpretive (van Manen, 1990). According to van Manen, the description of the phenomenon is an interpretation that "mediates" between the meanings of the data and the meanings of the researcher about the data (1990, p. 26) that is a philosophical viewpoint that resonates with my own beliefs as a researcher. van Manen's work is influenced by German philosophers, Jürgen Habermas, Edmond Husserl, and Martin Heidegger as well as by the French phenomenologist, Maurice Merleau-Ponty (Earle, 2010; Lopez & Willis, 2004).

Philosophical Underpinnings

Phenomenology is not only an approach to research; fundamentally, it is a philosophy with both epistemological and ontological camps that have influenced the development of knowledge in the twentieth century (Mackey, 2004). Because phenomenology has strong ties to philosophy, the researcher is "remiss" or careless in writing phenomenology unless a description of the philosophical assumptions of the chosen phenomenology is included (Creswell, 2007, p. 59). Articulating the philosophical underpinnings of my phenomenological study ensures that the methodological practices of the research are clearly linked to philosophical origins because the assumptions of philosophy drive methodological decisions (Mackey, 2004). The philosophical underpinnings are presented chronologically as critical theory progressed from pre-World War II Germany to post World War II French and Dutch articulations.

Consequently, Husserl, Heidegger, Merleau-Ponty, and Habermas's notions of lifeworld, being-in-the-world, presuppositions, interpretation, freedom, perception, and communicative

action provide an intellectual foundation for this inquiry into the lived experiences of the nursing student participants who communicate inter-personally in NPRs and ground the self-understandings of the researcher in the process of research. Moreover, a description of the works of Husserl, Heidegger, Merleau-Ponty, and Habermas and the ways in which their philosophy are related to van Manen's methodological research activities is found in the latter section.

Husserl

Phenomenology is rooted in the philosophy of Edmond Husserl who is both a phenomenologist and a transcendental philosopher. Husserl was originally a mathematician whose ideas about the sciences led to a means of understanding human experiences, that is, what an individual believes to be real in the world in which he/she lives (known as, his/her lifeworld) and what an individual experiences as his/her capacity for awareness and consciousness (intentionality) within that lifeworld (Husserl, 1970; Glenning, 2007). In Husserlian phenomenology, the researcher must actively abandon all prior knowledge (eidetic reduction) to get at the essential lived experiences (constitution of meaning) of the participants by using techniques, such as bracketing, to achieve this transcendental subjectivity (Husserl, 1970; Glenning, 2007; Russel, 2006). Moreover, Husserl lays claim to the existence of universal essences (eidetic structures) of all individuals who have an experience; in this way, there is only one correct interpretation or true nature of a phenomenon, one that is objective and independent of history and context (Husserl, 1970). Husserl's notion of radical autonomy implies that humans bear the responsibility and freedom for impacting culture and society (Earl, 2010; Husserl, 1970).

Heidegger

German philosopher, Martin Heidegger was a student of Husserl, yet his work was a departure from his teacher in that Heidegger's focus is ontological (Davis, 2010). In other words, the meaning of the individual's lived experience is situated in the framework of the world in which that individual lives (lifeworld to Heidegger evolved to being-in-the-world) (Heidegger, 1962). Lived experience (being-in-the-world) to Heidegger refers to the way in which individuals experience and understand their world, a capability that he called dasein (Heidegger, 1962; Mackey, 2004). In this way, Heidegger rejects Husserl's notion of intentionality for an existential phenomenology of being-in-the-world (Davis, 2010). Heidegger also discarded Husserl's concepts of bracketing and reduction due to his view that the researcher's 'presuppositions' or prior knowledge are a useful part of the inquiry and impossible to ignore (Davis, 2010; Heidegger, 1962). Therefore, Heidegger claims that interpretive research is a product of both the meanings of the participant and the researcher. Additionally, Heidegger's existential concept of situated freedom differs from Husserl in that individuals are free to make their own choices, but they do so within the conditions of the situated time and space of their daily lives (Heidegger, 1962).

Habermas

German philosopher, Jürgen Habermas was informed by the significant historical events of his early and mid-life, namely the World War II, the development of the Federal Republic of Germany, the Cold War, the fall of the Berlin Wall, and the fall of the Soviet Union (Finlayson, 2005). As a young man in the 1940s and 1950s he studied the work of Martin Heidegger but was disillusioned by Heidegger's alignment with the Nazis (Finlayson, 2005). He became interested

in the work of Marcuse, Marx, and Adorno as he developed his first major theories (Thomassen, 2010).

Habermas first published *Theory of Communicative Action* (TCA) in German in 1981 with the aim of developing a theory and critique of modern society (Habermas in translation, McCarthy, 1987). Habermas is an interdisciplinary theorist who is interested in "how social order is possible" (Fultner, 2011, p. 55). The TCA is both a sociological and philosophical work, for Habermas combined a theory of action and language (sociology) with a theory of rationality (philosophy) (Thomassen, 2010). Within the two volume text, Habermas critiques thinkers such as George Herbert Mead, Karl Marx, Emile Durkheim, Max Weber, Georg Lukacs, and Talcott Parsons then uses (what he views as) the most useful aspects of their theories as the basis for his own theory of communicative action and reason. Habermas also used the *speech act theory* of Austin (1975) and Searle (1969) who viewed language as part of social action and reality, to explore those aspects of language which establish normative relationships between two or more speakers (Thomassen, 2010, p. 63).

Communicative action is defined as any action oriented toward mutual understanding within the social world (Habermas, 1987). When an individual makes a speech act, mutual understanding is arrived at through different claims (or worlds): truth (i.e.: one claims to represent a cognitive perception in the external world), normative rightness (one claims to establish relationships with others), or truthfulness (one claims to share his or her intentions) (Habermas, 1987). To understand each other, the listener must be able to comprehend the reasons behind the speaker's claims (the validity of the claim), and if the listener does not, the speaker may be asked to defend his or her claims through discourse (Habermas, 1987).

Language and action take place against a shared background where certain norms are taken for granted, what Habermas calls the *lifeworld* (Habermas, 1987, p. 123-124). This lifeworld is then reproduced through communicative action, for the mutual understandings transmit and renew "cultural knowledge, socially integrates individuals and creates solidarity among them..." (Habermas, 1987, p. 137). Stated another way, Habermas argues that communication has the power to create community, which in the case of nurses, is the culture of the profession of nursing and the way in which that culture plays out in the individual health care contexts or units within which nursing is practiced. When a nursing student communicates with nurses and clients, this individual attempts to achieve a mutual understanding with other nurses and clients about what it means to be a nurse. Thus, the nursing student negotiates a new social role as a nurse.

Further, Habermas contrasts the lifeworld with the system, the separate entity which functions to reproduce goods and services (Habermas, 1987). He argues that problems or *pathologies* occur when the system encroaches upon or *colonizes* the lifeworld (Habermas, 1987, p. 364). When the system colonizes the lifeworld, communication between actors shifts from sincere, rational, reciprocal attempts at achieving mutual understanding shift to a strategic orientation towards success in the form of power (Habermas, 1987).

Merleau-Ponty

Maurice Merleau-Ponty was a pre-eminent French phenomenologist who was interested in the science of phenomenology. In his seminal work, *The Phenomenology of Perception* (1962), he argued that human beings' original awareness of the phenomenon resides in perception. Perception or the perceiving subject (whom Merleau-Ponty calls the body) gives humans access to the world, and all human behaviour occurs within, and to a certain extent is

determined by, the context of experience in the world of other people, situations, and objects (Glendinning, 2007; Merleau-Ponty, 1962). In short, people are in the world, and it is within this world that they learn about and become themselves, which is known as a dialectical relationship (Merleau-Ponty, 1962). As a result, individuals are continually in a state of learning, growing, changing, and adapting within a world that is also constantly undergoing change and flux. Within this dialectical relationship, Merleau-Ponty, who has unsurprisingly been called "the philosopher of ambiguity" (Sadala & Adorno, 2002, p. 286), claims that the meaning of the phenomenon depends on the individuals' perceptions of the phenomenon from different standpoints in time and space, and as such, the phenomenon's structure is merely a convergence of multiple perspectives (Merleau-Ponte, 1962), not a single universal truth as Husserl asserted.

Thus, it is significant that the development of critical theory is increasingly democratic as professions such as nursing shift from authoritarian to democratically apprehended educational programming.

Linking Philosophy to Research Methodology

Giorgi, a leading researcher in phenomenology, makes a critical argument for the difference between philosophical and scientific phenomenology (the new phenomenology). Giorgi (2000) asserts that, while researchers must acknowledge the philosophical origins of phenomenology as I have done in the above section, one cannot follow the exact methods of philosophers such as Husserl or Heidegger, or one would be practicing philosophy, not research. Stated another way, phenomenological nursing education research is a human science, not a subfield of philosophy. For phenomenology to be useful to nursing education, it must be used in a way that is helpful to praxis (Giorgi, 2000). As a consequence, this research study necessitated

a practical scientific phenomenology that could be used to carry out research about nursing students lived experiences of interpersonal communication in NPRs.

Max van Manen's Methodological Research Activities

The scientific phenomenology for this study is in the work of Max van Manen. van Manen describes his method of human science research as "an active and ongoing interplay of six distinct research activities" (Earle, 2010, p. 289) that provides researchers with methodological guidelines. In this study, the phenomenological method used for data collection and analysis will be based upon van Manen's (1990) six methodological research activities: (1) turning to the nature of the lived experience, (2) investigating experience as it is lived rather than as it is conceptualized, (3) reflecting on the essential themes that characterize the phenomenon, (4) describing the phenomenon through the art of writing and rewriting, (5) maintaining a strong and orientated relationship to the phenomenon, and (6) balancing the research context by considering the parts and the whole (van Manen, 1990, p. 31). Below is a preliminary description of van Manen's research activities as grounded in the work of the phenomenological philosophers, Husserl, Heidegger, and Merleau-Ponty. The philosophical underpinnings of van Manen's phenomenological research methodology must be articulated for his philosophical assumptions in phenomenology drive his methodology.

Turning to the nature of the lived experience. van Manen's first research activity is rooted in the researcher's commitment to understand or make sense of the phenomenon. Following the work of Heidegger and Merleau-Ponty, van Manen (1990) claims that researchers are responsible for being aware of their presuppositions (prior knowledge) and perceptions throughout the research process. In this way, van Manen questioned whether the researcher can truly put aside his/her presuppositions through bracketing, as Husserl recommended. Because

van Manen recognized the researcher's interpretive role in the process of research, as per Heideggerian thinking, van Manen does not embrace the idea of bracketing in his methodology.

Investigating experience as it is lived rather than as it is conceptualized. In van Manen's second research activity, the researcher immerses him/herself in the phenomenon to gain a deep and meaningful understanding of the lived experience of the phenomenon (van Manen, 1990). To *investigate the experience as it is lived* reflects Heidegger's notion of being-in-the-the world and speaks to the importance of understanding the participant's dasein (how that individual experiences his or her situated world) rather than what the participants believe to be real to them (as per Husserl) or what the lived experiences of the participants mean within the researcher's perception (as per Merleau-Ponty).

Reflecting on the essential themes that characterize the phenomenon. van Manen's third research activity is to discover the "essence" of the participants' lived experiences through reflection on the themes ("meaning units") that give structure to the phenomenon. van Manen explains essence "as a universal which can be described through a study of the structure that governs the instances or particular manifestations of the essences of that phenomenon" (1990, p. 10). This notion of a universal essence is Husserlian thinking, as Husserl stated that a phenomenon is made up of universal essences (eidetic structures) that are the true nature of the phenomenon.

Describing the phenomenon through the art of writing and rewriting. In van Manen's fourth research activity, he claimed that the phenomenon is described through the "art of writing and re-writing" (1990, p. 31). In phenomenological writing, the researcher writes extensively about the themes to analyze and extract the essence of their meaning. Van Manen (1990) states that "writing distances us from the lived experience, but by doing so, it allows us to

discover the existential structures of experience" (p. 127). This research activity echoes Merleau-Ponty in that, by writing and rewriting about the participants' perceptions, the researcher's perceptions of the phenomenon expand, evolve, and mature.

Maintaining a strong and orientated relationship to the phenomenon. In this fifth research activity, the researcher attempts to provide the most focused and least superficial interpretation of the phenomenon by staying focused on the lived experiences of the participants (van Manen, 1990). In the words of van Manen, "To be oriented to an object means that we are animated by the object in a full and human sense. To be strong in our orientation means that we will not settle for superficialities and falsities" (1990, p. 33). According to Husserlian thinking, a researcher can obtain the essence of the phenomenon by staying focused on lifeworld of the participants, not on the field of consciousness nor on perceptions of the researcher as Merleau-Ponty argued. Put another way, in spite of the expanded understanding of the phenomenon through the previous research activity, the researcher must see the data for what it is, not as that which the researcher wants it to be in his/her own mind and interpretation.

Balancing the research context by considering the parts and the whole. In this last research activity, van Manen (1990) asks the researcher to recognize that the that experience of an everyday phenomenon or "abiding concern" occurs within the interconnected entirety of the experience (p. 30). van Manen emphasizes "the experience of a phenomenon in a whole experience" (Dowling, 2007, p. 138) which follows the work of Heidegger who claimed that all phenomenon are situated within the time, space, and meaning of the participants' daily lives and Merleau-Ponty who described the interrelationship of people, objects, and situations as a dialectical relationship.

Methods

As the philosophical foundations of this phenomenological study have been established above in the first part of this chapter, this next section describes the process of research. More specifically, the research procedures for this study will be described in terms of: the credibility and reliability of the data, study participants, data collection and analysis, and ethical considerations.

Reliability and Credibility of the Data

The trustworthiness of qualitative research differs from quantitative research because positivist (qualitative) concepts of reliability and validity are not addressed in the same way in qualitative research. Many qualitative researchers use alternative terminology from positivist researchers in an attempt to distance themselves from the positivist paradigm (Shenton, 2004). Two such researchers are Lincoln and Guba (1985) who proposed that the criteria for trustworthiness in qualitative research are credibility, transferability, dependability, and confirmability.

Because Lincoln and Guba (1985) argue that credibility is one of the most significant criteria in establishing trustworthiness, I have ensured credibility in this study by demonstrating that I had adequate access to participants who have lived experiences of the phenomenon, and who were willing and able to share these experiences with the researcher (Porter, 1999; Graneheim & Lundman, 2003). Moreover, credibility was obtained through a series of checks or checkpoints in the process of inquiry, such as, extensive debriefing with my doctoral advisor and the committee through drafts, and member checking with the nursing student participants (Chwalisaz et al., 2008; Graneheim & Lundman, 2003). The feedback of member checking is an integral part of phenomenology (Bradbury-Jones, Irvine, & Sambrook, 2010; van Manen, 1990)

because member checks verified data interpretation, validated themes/eidatic structures and confirmed the interpretations of the participants who have lived experience of the phenomenon (Bradbury-Jones et al., 2010). Consequently, the member checking was to negotiate and merge the meanings of the phenomenon of participants with those of the researcher and vice versa, which is central to van Manen's hermeneutic phenomenology.

Further, Lincoln and Guba (1985) stress the link between credibility and dependability and argue that a researcher's demonstration of credibility largely covers a demonstration of dependability. Dependability means that the research findings are consistent such that they could be repeated. However, I have focused on reliability (instead of dependability as Lincoln and Guba suggest) because reliability is based on the understanding that, although participants have differing perspectives of their lived experiences of the phenomenon, a sameness or essence, arises from within this variability of the data (Osborne, 1990). In other words, upon reading the interpretive description of the phenomenological research, the participants who have had the lived experience of the phenomenon recognized their own experiences in the description. Reliability was thus ensured when I clearly outlined the philosophical underpinning of the research which was reflected in the methods used to collect, analyze, and interpret the data (Lowes & Prowes, 2001). This methodology section has clearly outlined the ways in which van Manen's six research activities were used to arrive at the essence of the phenomenon of nursing students' interpersonal communication on NPRs.

More specifically, I have admitted my predispositions, that is, van Manen's six research activities meant that steps were taken to ensure that the findings are the result of the experiences of the participants rather than my own, which is the criteria for conformability according to Lincoln and Guba (1985). I have also used tables to demonstrate my audit trail which allows the

integrity of the research to be scrutinized (Shenton, 2004). This methods section describes in detail the ways in which access to the participants was obtained and the member checking procedures, the transcripts, and descriptive interpretation stages of the research.

Lastly, transferability according to Lincon and Guba (1985), is the least reliable concept of their criteria because the findings are defined by the specific context of the university and nursing practice cultures of the nurses and participants in this study. While their experiences might be an example of the broader phenomenon of nursing students' lived experiences of communication on NPRs, the small sample in the particular rotations makes it difficult to demonstrate that the findings are transferable to other nursing education programs or provincial health care systems. However, I have provided a rich description of the phenomenon such that other scholars can read these findings and determine if the findings are transferable or applicable to their setting or situation.

Study Participants

Due to the phenomenological nature of this study, the 12 participants in this study were individuals who had experience of the phenomenon of interpersonal communication in NPRs and were able to articulate their lived experiences (Creswell, 2007; Osborne, 1990). I had aimed to recruit 10 to 12 participants (including 1-2 males as representative of the male population in nursing education) because sample sizes for phenomenological studies range from 5-25 participants (Creswell, 1988), and data saturation was achieved, meaning that the information from the participants was no longer leading to more insight into the phenomenon. Therefore, participants were included in this study if they: (1) had completed Senior Practicum and (2) had experiences of interpersonal communication as part of providing care on Nursing Practice Rotations (NPR)s which they were willing to share with the researcher.

In this study, I asked participants to look back on their experiences and share their perceptions of relationships and communication with nurses and clients in the NPRs of their nursing education. While the participants agreed to reflect on their NPRs, the majority (11 of the 12 participants) requested interviews in coffee shops (eight participants), their parents' homes (two participants), and a city park (one participant). Only one participant asked to meet at the Faculty of Nursing. Initially, I assumed that their preferences were simply a matter of convenience as I travelled to eight different Winnipeg neighbourhoods and two rural Manitoba townships. However, as I listened to the participants' experiences, I came to the conclusion that the majority of the participants had wanted to meet me where their nursing education had not taken place. In essence, they were willing to *look back* on their NPR but unwilling to *go back* to nursing education.

Stakeholders. Prior to the proposed research, I had obtained written permission from the Associate Dean of Research at the Manitoba Centre for Nursing and Health Research (MCNHR) at the Faculty of Nursing for formal access to students for the purposes of research. The study was approved by the Education and Nursing Ethics Review Board (ENREB) at the University of Manitoba where the study took place. Upon securing permission from above administrative stakeholders (Devers & Frankel, 2000), I made contact with the Course Leader for Senior Practicum who confirmed that 99 nursing students were due to complete their Senior Practicum rotation in late July, 2014. The names of sites were deleted from the data, as well as the location of these sites.

Sampling strategies. Purposeful sampling was used in this study as this form of sampling is consistent with the phenomenological goal of exploring individual nursing student experiences within a common experience of interpersonal communication in NPRs because it

will intentionally sample individuals who can best inform the researcher about the phenomenon (Creswell, 2007). The form of purposeful sampling in this study was snowball sampling which "identifies cases of interest from people who know people who know what cases are information rich" (Creswell, 2007, p. 127). This step ensured that nursing students were given the opportunity to participate, yet they did not feel coerced into the research (Bradbury-Jones & Alcock, 2010; Houghton, Casey, Shaw, & Murphy, 2010). Nursing students at the end of their Senior Practicum were recruited by an email (the formal letter on Faculty of Education letterhead was pasted directly within the body of the email) (See Appendix A) to participate from the MCNHR by a Research Technician. This email was sent twice by the Research Technician at my request, once in late July and once in early September. In the email, students were asked to contact the researcher (me) by email to express their interest in the study. The email had the advantage of connecting with students in a way that is convenient for them, for the students had completed their studies and NPRs and were either studying for their licensure examination in nursing and/or working as a graduate nurse. To avoid a potential conflict of interest, the four Senior Practicum nursing students who were supervised by Dr. Wanda Chernomas, a member of my Doctoral Committee, were excluded from the study as stated directly on the Invitation to Participate in the study (See Appendix A).

Once a nursing student sent an email message to me, I emailed (See Appendix B) or called the student (if the student provided his or her phone number and indicated this preference) to arrange a meeting with the researcher (myself) at a location and time that was convenient for the student. Again, the meeting locations in this study included: coffee shops, a park, and one interview at my office at the Faculty of Nursing. The purpose of the face-to-face meeting was to

review and sign the consent form before participating in one semi-structured interview of 45 to 90 minutes.

Informed Consent

The means by which the participants' consented to participate in the study was voluntary, informed, and free of coercion. Furthermore, there was no deception, nor any partial disclosure in this study. Upon meeting the potential participant at a time and location convenient to them, I (1) introduced myself and describe the roles of researcher and participant, (2) confirmed that the student had completed Senior Practicum, and (3) shared the consent form with each potential participant by allowing time to read the consent form and to ask questions. The Consent Form (see Appendix C) explained the potential participant's involvement in the study, and in doing so, each individual was fully informed of the nature of the research and the right to cease participation from the study at any time (Osborne, 1990). The consent form is written in clear lay language and describes: the purpose of the study, the expectations of study participants, risks and benefits of participation, as well as contact information for the MCNHR, and the researcher.

The participant was made aware that he or she was contributing to a study that would gather knowledge to help other nursing students or educators in the future by advancing knowledge about interpersonal communication of nursing students on nursing practice rotations. Because participants in the health related disciplines are commonly motivated by a desire to help others (Karnieli-Miller et al., 2009), I needed to be clear and transparent about the way in which the data will be used. In the consent form, I explained to the participants that I would use the information that they provided to me (in the form of interview transcripts) to write a summative (i.e.: phenomenological) description of their experiences and perceptions of their

interpersonal communication with clients and nurses on nursing practice rotations. Participants were provided with a copy of the description by email and asked to confirm (again, by email) if the description represented their lived experiences and perceptions, and if not, how it might better reflect their ideas about their interpersonal communication in nursing practice rotations. I told participants that this description would form the basis of the results section for my PhD in Education. From this dissertation, I would use this information to publish journal articles on the same topics.

If the potential participant had completed Senior Practicum, was prepared to share his or her perceptions and experiences of interpersonal communication in Nursing Practice Rotations and had agreed to each and every aspect of the consent form, I formally asked the student to participate in the study.

Risks and Benefits

Each potential participant was made aware that he/she would face minimal risks in participating in this study (Bradbury-Jones & Alcock, 2010). As participants were asked to describe personal experiences of nursing practice rotations, including potential conflict therein, participants could have felt sadness, frustration, or confusion as they described these experiences. Thus, I carefully observed the participants as they described their experiences and watched for signs of upset or overwhelm; however, no participant needed to take a break or discontinue with the interview. Nonetheless, I was prepared in the unlikely event that the participant was/appeared distressed, I would have referred refer the participant to counselling services at the University of Manitoba. In keeping with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS2, 2010), the participants' wellbeing is the priority over the research. I also explained that as a participant in this study, the nursing student

would likely experience such benefits as strengthening of the self (the personal benefits of catharsis, for instance) and strengthening knowledge (substantive knowledge of communication and research, for example) (Bradbury-Jones, Stewart, Irvine, & Sambrook, 2011; Drury, Francis, & Chapman, 2007; Karnieli-Miller et al., 2009). None of the 12 participants became distressed or upset at any time during the interviews for this study, so the counselling resources were ready but not needed.

Anonymity and Confidentiality

For this study to be ethically sound, the participants' confidentiality had to be protected from deductive disclosure, which occurs when the individual traits or story details of the participant allow this individual to be identified in the research (Kaiser, 2009). First, participants' identities were protected during data collection by changing their names as well as changing the names of their Course Leaders, Site Leaders, CEFs, Buddy Nurses, Preceptors, clients, and classmates to pseudonyms. Second, the gender of the nursing student participants was also not identified in the transcripts/data/results due to the relatively limited number of male nursing students in nursing education. Male nursing students were recruited into this study in an effort to be inclusive despite the fact that males have higher attrition rates in this nursing education program. Most importantly, comparisons of male and female experiences/perceptions is not reported in this study; I did not link any one quote or perspective to male nursing students. Third, specific NPR sites and client conditions were excluded from the interview transcript (Kaiser, 2009). Fourth, when the participant received a copy of his/her interview transcript for the purpose of member checking, the participant was be asked to identify any information that must be deleted in order that the students, nurse educators, nurses and clients to remain confidential (Kaiser, 2009).

Interview transcripts are stored in a locked cabinet at 495 Helen Glass Centre for Nursing, and only Nathalie Piquemal and myself have had access to the data. Dr. Piqumal only had access to the interview transcripts and data in my office; she does not have her own copies. The consent forms and any key code to the pseudonyms are stored separately and securely from the interview transcripts. Transcripts, consent forms, and code to pseudonyms will be destroyed within two years of the study. I understand that I have a duty to treat personal information from the participants and the critical friend with respect and confidentiality.

Data Collection and Analysis

In this study, the phenomenological method used for data collection and analysis was grounded in van Manen's (1990) six methodological research activities. Data was organized around the theoretical frameworks of this study, Ecological Systems Theory and Critical Systems Theory.

Turning to the nature of the lived experience. van Manen's first research activity is based upon the researcher's commitment to understand or make sense of the phenomenon which, in this case, is my commitment to understand the nursing students' lived experiences of interpersonal communication in NPRs. To achieve this goal, I engaged with the phenomenon by considering my prior awareness, anticipation of meaning, and perceptions as an integral part of the project rather than bracketing out these presuppositions (van Manen, 1990). In practical terms, this activity implied that I explored the relevant research literature on communication in nursing in a review of the literature prior to data collection (see Chapter Two).

Second, I have reflected upon my personal experiences with/of the phenomenon to shape and reshape the phenomenological research question. My prior experiences of the phenomenon have been through conversations with either students or nurse educators, either in person or through email or phone, away from the NPR sites. Over the course of nine years in nursing

education, numerous students and educators have described to me their stories of nursing students who struggle with interpersonal communication with CEFs, Buddy Nurses, and clients in NPRs. My role as an educator in this regard was not mediation but rather to discuss the possible options with the student and to let the student decide the course of action, while my role as a colleague was simply to listen. Nonetheless, these conversations left me feeling concerned, not only for the well-being of individual nursing students, but also for the process of nursing education in NPRs. Through this reflection, I have determined that my initial presuppositions of the phenomenon are grounded in this concern for student nurses and nursing education (van Manen, 1990).

Investigating experience as it is lived rather than as it is conceptualized. In this second research activity, I experienced the phenomenon through the participants, as well as explored my interpretations and perceptions of their experiences. In other words, I recorded the participants' stories in interviews while writing my own story in my field journal as a researcher who has her own evolving understanding of the phenomenon (Nunkoosing, 2005). Since van Manen does not employ Husserlian bracketing but rather sees the interviewer's subjectivity as an inescapable part of the interview process as Heidegger did, the phenomenological interviewing will be a co-created by both the participants and I (Lowes & Prowse, 2001). van Maden cites Merleau-Ponty when he calls this a process a "reawakening" (van Maden, 1990, p. 32) for the researcher and the participants.

More specifically, I conducted semi-structured interviews with the participants to learn the way(s) they made sense of their experiences of interpersonal communication (Heidegger, 1962; Mackey, 2004). The Interview Guide (See Appendix C) was intended to establish rapport with the nursing student participant through informal conversation about future goals for nursing

as students were excited about their new roles as graduate nurses. Next, I prompted the students to discuss their lived experience of interpersonal communication with clients and nurses within the context of nursing culture. Details and interpretations of each research interview were reflected upon in my field journal as my own preconceptions needed to be explored throughout the process of research (Lowes & Prowse, 2001).

Transcripts were transcribed verbatim, and each participant was sent an email attachment of his or her transcript by email. Participants were given two weeks following the interview to read the transcript, reflect upon what was said in the interview, and request any deletions, additions, or changes (member checking). Consequently, each participant had his or her views accurately recorded in the data (Houghton et al., 2010) that theoretically increased the trustworthiness, accuracy, and validity of the findings (Karnieli-Miller, 2009). Any emails in this study were responded to promptly with a confirmation of having received the message, printed, and immediately deleted. The paper copy of the emails had the names, genders, and email addresses blacked out and stored with the transcripts.

Reflecting on the essential themes that characterize the phenomenon. In this third research activity, van Manen's three approaches to isolating the themes from the research data are: the (a) wholistic or sententious approach, the (b) selective or highlighting approach, and the (c) detailed line-by-line approach (van Manen, 1997).

(a) The transcript of each research interview were initially read to gain an overall sense of the information or a wholistic view as to the ways in which roles, relationships, and power shape nursing students' interpersonal communication (van Manen, 1990).

(b) Next, I analyzed the interview transcript a second time and identified themes using the theoretical frameworks of Ecological Systems Theory and Critical Systems

Theory by highlighting key words or phrases in the transcript related to *microsystem, mesosystem, exosystem, macrosystem, and chronosystem* as well as examining the data through the lens of power isolating any incidences of lived experiences of *coercive contexts* which impact on students' ability to engage in interpersonal communication with clients and nurses (van Manen, 1990). After all of the interviews were completed and the themes had been assigned to each interview transcript, I compared the themes across the different interview transcripts so that essential themes related to the two theoretical frameworks could be identified. I grasped the essence of the phenomenon by identifying structures that encompass the consciousness and perception of the lived experiences of the nursing students (van Manen, 1990).

(c) Then, I carefully did a line by line re-read each of the interview transcripts once more to confirm which essential themes appeared in each of the interviews (van Manen, 1990). Although I had, to this point, collected interview data on varying perspectives, voices, and lived experiences of a phenomenon, these perspectives had common meanings that allowed me to determine the structure of that phenomenon (Sadala & Adorno, 2002).

(d) At the same time, as I interpreted the data, the phenomenon's structure was understood within my own perspective which is yet another perspective that had to be taken into consideration as part of the story of the research (Merleau-Ponty, 1962; Sadala & Adorno, 2002). Nonetheless, from these essential themes, I composed a descriptive account of the nursing students' lived experience of interpersonal communication in NPRs.

Describing the phenomenon through the art of writing and rewriting. Following the research activity above, the description was written and rewritten until the essence of the phenomenon was described to the extent that the participants could recognize their lived experiences in the description. However, this phenomenological writing was not simply a matter of writing up the results of a phenomenological data analysis of the perceived experiences of the participants (van Manen, 2006), but rather the essences were fundamentally shaped by the language that the writer uses to convey them. According to van Manen (1990), the description of the phenomenon is an interpretation that "mediates" between the meanings of the data and the meanings of the researcher about the data (p. 26) as expressed through the filter of language. In other words, my own story and interpretation were weaved into the data collection through my choices in language. Truth is uncovered in the words of the writer, claims van Manen, as "Language substitutes itself for the phenomenon that it tries to describe" (1996, p. 718). The process of writing and rewriting forced me to put the essential meaning of the phenomenon into words in the form of an interpretive description, a text that is representative of the lived experience of the student nurses. van Manen (1996) described this phenomenological writing as the "dark enigma" of phenomenology as the writer "dwell[s] in the space of the text, where the desire for meaning leads" (1996, p. 719). From time to time, the writer may recognize the limits to which language can fully express the lifeworlds of others. To enhance the credibility of the data, peer debriefing with my advisor, Dr. Nathalie Piquemal, as to the analysis, themes, and written description, was invaluable.

Maintaining a strong and oriented relationship to the phenomenon. To have a strong and oriented relationship to the phenomenon means that the researcher does not separate theory from life, nor the lived experiences of the participants from the researcher's interpretation of

those experiences. In a conscious effort to remain open to the realities of the participants, the skilled qualitative researcher recognizes that his/her perceptions, biases, assumptions and viewpoints are part of the research project, but are not the purpose of the research. In this regard, two strategies will be employed. First, following the work of Geanellos (1998), I kept a field journal to identifying and challenging my presuppositions, and as an attempt to monitor the ways in which those presuppositions shaped my interpretation in the course of research (Lowes & Prowse, 2001). Second, I sent the written description of the phenomenon to participants by email to determine if they recognize their lived experiences of the phenomenon within that description so it is their stories, not only my story about their lived experiences, that was the outcome. I asked participants: how does this description compare to your experiences of interpersonal communication in NPRs? If the participants do not recognize their lived experiences within the description of the phenomenon, I have allowed my presuppositions override their voices. Validity of the phenomenological description is checked by the extent to which the description resonates with the participants or others who have experienced the phenomenon under study (Osborne, 1990). However, member checking at this stage also yields new or expanded upon data from the participants that must be taken account in the data analysis (Bradbury-Jones, Irvine, & Sambrook, 2010).

Balancing the research context by considering the parts and the whole. van Manen emphasizes "the experience of a phenomenon in a whole experience" (Dowling, 2007, p. 138). The experiences of the nursing student participants cannot exist in isolation; each individual's roles and circumstances were dependent on the roles and circumstances of the other(s). This effort to balance the parts and whole was an idea that I found particularly relevant given that I

explored nursing students' interpersonal communication using Ecological Systems Theory and Critical Systems Theory.

Positionality and Ethics

Qualitative research begins with the researcher's "vision and energy" to learn from the lives of the participants (Beitz & Bliss, 2005). As a nurse educator who has worked for several years with nursing students who struggle with interpersonal communication in their NPRs, both curiosity and concern has led me to the above research question. As a result, my positionality as the researcher who is also a nurse educator at the institution where the students studied needed to be carefully considered and negotiated within this qualitative study (Bradbury-Jones & Alcock, 2010; Edwards & Chalmers, 2002). My position within the research added to the complexity of this study because the researcher's interpretations in hermeneutic phenomenological research, according to van Manen, cannot be completely separated from the researcher's background and personal perspectives (van Manen, 1990). At the same time, this positionality affords me several advantages as a researcher related to access, rapport, and familiarity with the subject matter under study, for instance (Roberts, 2007). My potential bias is that I could too quickly assume that students' explanations of interpersonal communication with nurse educators, Buddy Nurses, or other nurses on the NPR are incidents of the misuse of power. Since I have done considerable research on the topic and met a number of distressed nursing students over the course of my career, this potential bias was managed by asking multiple follow up questions using the probes in the interview prior to drawing any conclusions about the data and resulting themes.

Bradbury-Jones and Alcock, at the School of Health Sciences of Bangor University in Wrexham, UK, have developed the Framework for Ethical Research Practice (2011) for use in nursing contexts, in particular, in research with nursing students as participants. Their framework includes key questions for the researcher within three areas: research contribution, research

relationship, and research impact. From the outset, I was honest with the participant about the nature of our partnership in the study (Karnieli-Miller, Strider, & Pessach, 2009) because the relationship between the researcher and the participant shapes the data that is collected and the quality or authenticity of the data. Some researchers have taken on roles as "mentor or elder sister" (Bhattacharya, 2007), "therapist or counsellor" (Drury et al., 2007), or "friend" (Motha, 2009) which makes the construction of knowledge into a blurry and confusing process that, in my opinion, threatens the rigor of the study. My stance as a researcher is that there ought to be a "we-ness rather than a friendship" (Roberts, 2007. p. 21), and I attempted to create "a welcoming, nonthreatening environment in which the interviewees are willing to share their personal stories" (Karnieli-Miller et al., 2009, p. 280). Therefore, I chose to check the Framework for Ethical Research Practice (Bradbury-Jones and Alcock, 2011) after each interview, after each participant replied with comments about his/her transcript, and upon receiving feedback from each participant about the description of the phenomenon. The Framework is used in nursing contexts, in particular, in research with nursing students as participants and includes key questions for the researcher within three areas: research contribution, research relationship, and research impact. I used the authors' framework as part of my own research for two reasons: (1) I find the questions within the framework invaluable in addressing the ethical complexities of research with student nurses as a nurse educator, and (2) the authors' intention is that the questions in the framework be used throughout the study as a means of ensuring ethical research practice with student nurse participants at all times, not just during data collection (See Framework, Appendix E).

CHAPTER FOUR: FINDINGS

In this study, phenomenology was used to explore the essence of the phenomenon of nursing students' interpersonal communication in Nursing Practice Rotations (NPR)s with nurses and clients. The specific hermeneutic phenomenological approach of phenomenologist Max van Manen (1990) was employed because van Manen combines descriptive and interpretive phenomenology. More specifically, van Manen claims that the description of the phenomenon is an interpretation that "mediates" between the meanings of the data and the meanings of the researcher about the data (1990, p. 26). Therefore, this findings chapter shares the participants' voices through their stories and anecdotes (their perceptions and experiences) of learning to communicate with clients and nurses on NPRs through the themes: Roles, Relationships, and Responsibilities in the first section of this chapter. Next, the interpretations and meanings that I (as the researcher) attach to the participants' lived experiences and perceptions are organized according the frameworks of Ecological Systems Theory and Critical Systems Theory within the last section on Theoretical Frameworks: The Themes.

In phenomenology, the researcher uncovers the meanings of lived experiences from the very individuals who are living (or have lived) the phenomenon (Creswell, 2007; van Manen, 1990). In this study, I investigated the lived experiences of nursing students who had communicated interpersonally with nurses and clients in NPRs as part of their undergraduate nursing education. This study included 12 participants whom I interviewed between August and November, 2014. The sample included ten females and two males between the ages of 22 and 44 at the time of interviews. In terms of diversity, ten participants are white Canadians one of which was foreign-born, one foreign-born Asian-Canadian, and one student of Aboriginal descent; three participants were mature nursing students. Ten students had passed each rotation and two participants had failed one (or more) NPR, then repeated the rotation and passed. Three

participants completed a rural NPR placement as part of their nursing education. To introduce readers to the various perspectives in this study and provide context for the findings, brief participant and researcher (myself) portraits, The Participants and The Researcher, are included in the first section of this chapter.

THE PARTICIPANTS AND THE RESEARCHER

The sharing of stories is not new in nursing, for nurses have told stories about nursing for generations (Baker, 1991; Wolf, 2008). Nurses tell stories to communicate their lived experiences as nurses and to interpret the meaning of these lived experiences (Baker, 1991; Bowles, 1995; Haigh & Hardy, 2011; Heinrich, 1992; Wolf & Langner, 2000). Their stories "help nurses share their nursing culture. They reveal the nature of nursing work, including its challenges, uniqueness, and privileged place" (Wolf, 2008, p. 324). Haigh and Hardy (2011) claim that storytelling communicates the norms, values, and realities of the nursing profession. As such, nursing students learn how to think like nurses through stories (Tanner, 2006), for nursing students' stories validate their lived experiences (Baker, 1991) and develop a voice within in a changing profession (Heinrich, 1992). There are 12 lived experiences of the phenomenon of interpersonal communication with clients and nurses on NPRs as a nursing student. Kathryn, Sophie, Meredith, An, Robert, Jillian, June, Danielle, Wren, Aubrey, Lena, and Isabella have shared their stories and anecdotes with me (the researcher) who has in turn interpreted the findings and determined themes which summarize the essence of this phenomenon. Each of us is briefly described below in terms of our most relevant contextual and personal factors in this study.

The Participants

The participants' confidentiality is protected from deductive disclosure through a number of strategies. A pseudonym (a fictitious name) was assigned to each participant. Genders, specific cultural or community affiliations were altered or deleted from the data. Personal characteristics of the participants have also been changed in the descriptions below so individuals cannot be identified.

Kathryn

Kathryn entered nursing education in her early thirties after spending "many years trying to find what [she] might be good at" (Kathryn). She had worked for lawyers, accountants, doctors, and finally in a medical clinic wherein she decided to enter nursing (Kathryn). Kathryn's lived experiences during nursing education were influenced by overcoming the illness of a dear friend, recovery from her own life-threatening health concern, subsequent barriers in her ability to learn due to her health, and a breakup with a long-term partner (Kathryn). Kathryn is strong, persevering, and unafraid of sharing her opinions. Kathryn was the only participant who did *not* report experiencing fear on NPRs. Kathryn was a client advocate; her anecdotes were of standing up to other nurses on her clients' behalf. Her comments led me to believe that she was distrustful of the nurse educators and nurses. She saw herself as protecting her clients from the health care system, including its nurses.

Sophie

Sophie entered nursing education as her first chosen career path. She has travelled abroad to developing nations where she was exposed to endemic poverty, and she identified her privilege as a White woman from the West as a result of these experiences. For instance, Sophie was concerned about the limited opportunities to learn about Indigenous health care or Lesbian,

Gay, Bi-Sexual, Transgendered, and Two-Spirited (LGBTT) health during her nursing education (Sophie). Sophie finds inner strength and conviction by reflecting on her values; in difficult moments during her nursing education, she would remember her reasons for studying to be a nurse (Sophie). She sees herself as "perceptive and intuitive" (Sophie), an "idealist and optimist", yet she admits that she went into nursing "somewhat naively" (Sophie). Sophie is thoughtful about her place in the world. For Sophie, NPRs were a challenging professional and personal journey. Sophie not only wanted to become a nurse, she wanted to be a confident and compassionate healer.

Meredith

Meredith described herself an unexceptional student in the classroom during her nursing education (Meredith), yet she had "street smarts" or an intuition and insight into the behavior of others on her NPRs. In her earliest rotations, she recognized that her performance (and grades) were impacted by the interpersonal communication style and unit culture of nurse educators and nurses. She described in detail the attitudes, behaviours, and unit cultures she would (and would not) tolerate among her nurse colleagues in her professional life as a nurse (Meredith). When nursing students were invited to participate in the study, Meredith sought me out early as a sounding board for her experiences, some of which had deeply challenged her morally and ethically. She had a broad perspective that was unique to a young woman in her 20s, "People said that it [NPRs] was going to be hard but that you can do it. Hundreds of us [nursing students] do it every year..that's kinda what got me through, hundreds of people do it and there are thousands of nurses out there; they've all had to do it, so surely I can make it through too" (Meredith). Meredith was candid, open, and thanked me for my interest in the experiences of nursing students.

An

An and his immediate family had migrated from Asia to Canada ten years prior to our interview for this study. He told me that communication with clients was "a bit scary because sometimes I was alone and I have a strong accent and my language…sometimes, I have to repeat many times for them to understand what I say" (An). English was also a barrier in communicating with nurses, so he felt it was best to be upfront with the nurses; "I always told them, 'I have weakness in English. It's a barrier that takes me two or three times longer [than other students] to write a paper. Any paperwork [charting or care plans] takes much longer. And communication is difficult as well…I have to think twice before I am speaking. It's frustrating sometimes, you know. I cannot express things that I want to express" (An). At times, An's admission about his English language difficulties elicited additional support or mentorship from the nurses. Other times, he felt vulnerable on the unit because Course Leaders and CEFs watched An more closely than other students for any mistakes, miscommunications, or unsafe practice (An). In fact, some CEFs directly communicated to him that he would be measured against the same standards as the other Canadian-born students (An). He often watched the other students and "imitated them" (An) to learn how to communicate and find his way on the unit.

Robert

Robert was a mature minority student who had worked for several years and raised a family before entering nursing education (Robert). When he shared his experiences communicating with clients and nurses, Robert used colloquial expressions, joked, and laughed frequently. He told humorous stories and anecdotes, in spite of the fact that many of his interactions with clients and nurses were intimate, acute, and scary for him. For example, when some of the busy and experienced nurses were "having one of those days", they were "on me like

white on rice"; they would "throw you to the wolves", "take your head off", and "heaven help you if you interrupt them!" (Robert). Robert would 'go with the flow' of any situation, yet he communicated to me that he understood the gravity of nursing work, the caring nature of many nurses roles, and the importance of his nursing education to his family's future. Robert had a history of hardship under his warm, easy-going, jovial persona. He told me that "Most people do not realize I am of Aboriginal descent" (Robert). Some of his immediate family members are residential school survivors, and he had "felt the impact personally" (Robert).

June

June follows in the steps of previous generations of nurses in that she grew up in a rural community and left home to pursue nursing education after high school (McPherson, 2003). June is also strikingly similar to public perceptions of young nurses of the first half of the 20th century in appearance and comportment because June is dedicated, hardworking, caring, yet all the while, very beautiful in her physical appearance. In fact, June resembles the attractive young nurses on the posters for the Canadian Red Cross (Canadian Nursing History, 2014) or other wartime images. June could have been the kind of nurse that young men of the war effort called their "Angels of Mercy" (McMaster University, 2013, para 1.). June appears to be unaware of the potential influence (or privilege) of her appearance on nurses and clients which I found endearing. She spoke in quick excited bursts of energy (starting a new sentence before she had finished the previous sentence) about how much she was absorbed in, influenced by, and rewarded through the knowledge, tasks, and relationships of nursing practice. To June, inter-personal communication in nursing is about "picking up the vibe" of the situation then carefully choosing her battles.

Jillian

Jillian is not who many mainstream Canadians would expect her to be upon first meeting her. She wears distinctive clothing to indicate her alliance to her faith based community. She is hard-working and has a strong desire to help others (Jillian) that may or may not be linked to her faith or upbringing. Given her modest dress and roots, many people might perceive her to be shy, passive, quiet, reserved, or even old-fashioned. However, any such pre-judgments or assumptions are incorrect, for Jillian is independent, clever, and a highly insightful thinker who can be assertive and who finds humour in human behavior. While she occasionally pronounces a word in a way that reveals that she speaks another language, Jillian uses expressions common to other mainstream young people her age like "she went to bat for me", "You kinda felt that you were on a fine line", I got "wound up" at times, "I gotta learn this sooner or later…"(Jillian). Jillian's experience was that some nurse educators and unit nurses helped nursing students learn, while others did not want to help students but rather saw them as an ignorant and time consuming nuisance (Jillian).

Danielle

Danielle is a life-long learner whose comments reveal that she expected a fair, structured, and supported learning during her nursing education. In turn, she saw every nursing rotation, every class, and each interaction as an opportunity to develop her nursing knowledge and skills. Danielle "enjoyed every rotation" (Danielle), and admitted that "I miss [nursing] school. It went by so quickly!...I don't know if it's more the friends and seeing people that I knew every day…I also really like learning. And now that I am in nursing it won't be as often, but there are courses that you can take out there, thankfully, so I have been doing those courses. It's nice to know that your education doesn't stop which I was kind of scared for my first two months [after completing

a degree in nursing]" (Danielle). Danielle was intrinsically motivated by a sense of personal fulfillment when learning from nurses and with fellow nursing students. She learned to communicate on NPRs through observation of nurses' communication and practice with her clients. She was the witness, rather than the target, of power struggles on her NPRs.

Wren

Wren was "adrift" in her life. She had "really honestly sort of floated through the [Baccalaureate] degree [in Nursing] not sure what the next plan would be. Now, I'm trying to figure that out. Bedside nursing is not something that I see myself doing for a very long time. It wasn't something that I really wanted to do" (Wren). Moreover, Wren's previous experiences with formal education had been negative, "I went through high school very quickly because I hated it" (Wren). During her nursing education, she rarely engaged with nurse educators, "other students developed more of a relationship with their teachers and talked more in class, and I didn't really do that so much" (Wren). Wren claimed that she was better suited to self-driven or self-directed project work than intimate and power-laden relationships with clients and nurses (Wren). NPRs were intimidating, awkward, and nerve-wracking for Wren. She learned to communicate on NPRs through trial and error, and through the encouragement of her of classmates. As a nursing student, she saw herself as "on the bottom rung" of the system and purposefully avoided conflict whenever possible.

Aubrey

Aubrey decided to enter nursing education after an experience with a "terrible night nurse" following minor surgery in her teens. Since this nurse "just made it seem like she didn't have the time of day" for her in hospital, Aubrey thought "maybe I should be a nurse and be nothing like her" (Aubrey). Aubrey finds meaning in nursing, not only in the timely and accurate

tasks of nursing practice, but also through intimate acts of care such as providing bed baths or helping a client with her sweater (Aubrey). However, Aubrey summarized her NPRs as "anxiety provoking" due to the inconsistent and unpredictable support of nurses with whom she had relationships (Aubrey). Aubrey was skeptical of nurses whom she suspected of using nursing students as free labour and did little teaching. In her three years of NPRs, Aubrey spent a great deal of time worrying, feeling nervous, double checking, losing sleep at night, clinging to her CEFs, or clarifying expectations with nurse educators (Aubrey). Aubrey's stories demonstrate that she was a hardworking, conscientious, stressed, and, at times, an overwhelmed and exhausted nursing student. She doubted her choice to enter nursing on more than one occasion during her nursing education.

Lena

Lena grew up knowing that caring for others was an integral part of her identity (Lena). She was a high achieving student who chose nursing rather than medicine because she wanted a balanced life that included more time with clients (than physicians have with their clients) as well as community and personal involvements in a life outside work (Lena). However, Lena fast-tracked her nursing education, thereby taking theory courses and NPRs each semester for four consecutive years. Lena admitted that she was "brain exhausted" by the end of her studies (Lena). Lena feels that nursing is her calling and that each area of nursing practice has its own "inspiration and joy" (Lena). Soft-spoken, reflective, and thoughtful, Lena found it difficult to "click with the blunt nurses" (Lena). However, she was quietly determined; she encouraged her fellow nursing students to speak out for themselves against the kind of nurses who "eat their young" or who believe that nursing students "have to serve [their] time in the trenches" (Lena).

Isabella

Isabella has always considered herself to be "a helpful person" (Isabella), and in our interview, she expressed confidence, competence, and an outgoing nature. She was the person that her classmates in junior high, high school, and nursing education could count on to know "when assignments are due, when are classes, and those little things" (Isabella). Isabella got involved in faculty and student led events, and she actively cultivated mentor-mentee relationships with her nurse educators. To learn interpersonal communication on NPRs, she observed nurses communicate and got involved in care at every opportunity without being "a hindrance" to the nurses (Isabella). Isabella had chosen nursing education rather than pharmacy because "there just wasn't enough interaction with humans [in pharmacy]" (Isabella). It was her aunt's experiences and stories of neonatal nursing that led Isabelle to pursue nursing education.

The interviews for this study occurred at the crossroads of the participants' completion of nursing education and their commencement of first jobs as graduate nurses. At this juncture, seven participants expressed their relief at completing their nursing education (An, Aubrey, Jillian, Kathryn, Meredith, Sophie, Wren) and five told me of their excitement and rewards of caring for clients as a 'real paid nurse' (Isabella, June, Kathryn, Meredith, and Robert). Two participants shared that they missed the learning and camaraderie of nursing education (Danielle, Wren), and two others worried that there was so much more to learn as a nurse (Aubrey, Jillian). Three participants admitted that they had doubts about their future careers as nurses and were thinking about leaving the profession (An, Sophie, Wren). In sum, the participants were at different stages of letting go of nursing education and moving forward into their lives to discover where nursing may or may not take them.

The Researcher

My position within the research study must be explored in this study because the researcher's interpretations in hermeneutic phenomenological research, according to van Manen (1990), cannot be separated from the researcher's background and personal perspectives. Within my former role as Communications Instructor, I had come into contact with seven of the participants (An, Kathryn, June, Aubrey, Sophie, Lena, and Jillian) prior to this study. Two years before this study, I had had appointments for academic writing support with Kathryn, June, Sophie, and Aubrey. I had been aware of An's English language concerns from one discussion with a nurse educator colleague who was concerned about his progress two years before the study. Nine months prior to the study, I had come into contact with Lena in two meetings related to a Faculty-wide project. Because I had never formally evaluated nursing students, but rather, my previous role had been to support the students in their academic writing, this positionality afforded me advantages as a researcher in terms of access and rapport. In other words, some of the participants may have volunteered for the study because they already trusted me to keep their information confidential and act positively on their behalf in framing their stories with my words and ideas.

I had not had any former contact at the Faculty of Nursing with five participants (Robert, Meredith, Isabella, Wren, Danielle). Therefore, I attempted to create "a welcoming, nonthreatening environment in which the interviewees are willing to share their personal stories" (Karnieli-Miller et al., 2009, p. 280). I allowed more time for the participants to get to know me (and me them) through informal conversation at the start of the interview. At times, I let them share ideas about nursing education that were beyond the scope of the study before guiding them back to the initial question.

With all participants, I checked the Framework for Ethical Research Practice (Bradbury-Jones & Alcock, 2011) after each interview, after each participant replied with comments about his/her transcript, and upon receiving feedback from each participant about the description of the phenomenon. The framework was useful in defining my role as a researcher (as opposed to a former instructor or mentor) because it helped me set boundaries when I began to have feelings of attachment and concern for participants. For example, I would be genuinely interested to know what happens next in several participants' lives as nurses beyond this study. However, reviewing the Bradbury-Jones and Alcock (2011) framework after each interaction kept me focused on the purpose of the research and the outcomes of such knowledge for nursing students in the future.

THE ESSENCE OF THE FINDINGS

Upon using van Manen's phenomenological method for data collection and analysis, the goal of this phenomenology was to "reduce individual experiences within a phenomenon to a description of the universal essence" (van Manen, 1990, p. 177). I grasped the essence of the phenomenon by identifying that which is the consciousness and perception of the lived experiences of the nursing students (van Manen, 1990). Essentially, I interpreted the nursing students' individual lived experiences and created a description of what it means for these nursing students to communicate interpersonally in NPR with nurses and clients in order to answer the essential phenomenological question: what is the essence of this experience? I was assured that this essence was done in accordance with the principles of phenomenology and that my description has reflected the essence of the phenomenon because several participants recognized their own experiences in the description. Comments by email from the participants included, "your summary is wonderfully succinct and very accurate to my experience and those

of my peers", "I feel like you hit the nail on the head", "The cumulative description of your findings still felt very true to my own experiences and those of my friends from school", and I wasn't the only one who felt the way I did (two comments). I think "it describes a lot of my feelings very well."

Readers are cautioned that the participants' lived experiences and perceptions need to be contextualized within a broader social landscape of nursing education and the health care system. As such, issues of power will be problematized and theorized in Chapter Five, the Discussion. Certainly, different positionings or perspectives, such as that of various nurses for example, would generate alternative lived experiences and perceptions. However, the scope of this study is to explore the lived experiences and perceptions of nursing students as they learn to communicate with nurses and clients on NPRs, and the essence of the 12 lived experiences and perceptions of the participants in this study is as follows:

The 12 participants' lived experiences of interpersonal communication with nurses and clients on nursing practice rotations were scary, anxiety-provoking, paralyzing, terrifying, and stressful. The participants consistently described feeling overwhelmed, unprepared, and thrown into a "sink or swim" situation. Principally, they experienced anxiety and fear about how the other nurses (the CEFs, Buddy Nurses, Course Leaders, staff nurses, and Preceptors) would behave towards them because they had experienced inconsistency in the communication style, attitudes, and behaviours of these nurses on their NPRs. More specifically, the participants had perceived through communication and relationship that they were: (a) guided, supported, and encouraged as a learner to increasing independence; (b) a liability, hindrance, or burden; and (c) extra set of hands in the care of clients.

However, the participants' perceptions were that their relationship with the CEF was a linchpin in learning to fit in or belong on the NPR. While the participants experienced some CEFs as open, receptive, supportive, trusting, or competent in their interpersonal communication and relationships, they also had negative experiences of CEFs whom they perceived to be disinterested, hyper-vigilant/hovering, or whom the participants felt had aggressive attitudes and behaviours towards students. In fact, some participants claimed that their positive or negative experiences of communication and relationship with CEFs had the potential to turn them onto or off an area of nursing practice.

All participants reported that they had been expected to communicate with clients on NPRs with little or no coaching, guidance, or formal instruction in interpersonal communication. For several participants, first client encounters/interactions were nerve-wracking, stressful, intimidating, and scary as they felt insecure and unprepared in their role as nursing students. Those participants who had previous life experiences of communicating within public in service industries had less fear and apprehension when approaching clients and building rapport and relationships as part of care. All participants claimed that they had improved their interpersonal communication with clients by observing other nurses interact with clients. They observed nurses whom they perceived to range from effective (who showed students how to listen to clients, respond appropriately to clients, use touch, and manage their own emotions as nurses) to ineffective (who were task oriented rather than caring, impersonal, and lacking respect for the dignity of the client) models of interpersonal communication and relationship with clients. Participants also perceived boundaries with their clients differently; some participants claimed to care for their clients like they would family members while others set boundaries based on their perceptions of confidentiality, professionalism, and therapeutic relationships. Several

participants expressed their desire to initiate holistic nursing care through interpersonal communication with their clients. However, these participants felt that holistic nursing care was often discouraged due to a lack of time, high client load and demand, and lack of prioritization which was source of disappointment and discouragement for several participants.

Interpersonal communication and relationship with nurses within the context of the unit culture was important to half the participants who recognized that they had to learn to identify and interpret the context of each NPR through the nurses' words, body language, tone of voice, attitudes and relationships in order to adapt to the unit culture and establish communication and relationships with the nurses on that NPR. The participants described their experiences of the "vibe" of the unit culture as primarily positive (in which nurses communicated in ways that were knowledgeable, supportive and compassionate, and an advocate with clients and with each other) or negative (in which nurses communicated in ways that fostered disloyal and distrustful interpersonal relationships between nurses, complaining, the perception of a lack of time, disinterest in clients, and intolerance of nursing students). Over the course of three years of NPRs, participants had experienced unit cultures that the participants felt were supportive, cohesive, and compassionate in communication and relationship while other unit cultures were perceived as abrupt, aggressive, confronting, and tense. The unit culture of the individual unit was more important to the participants' experiences of interpersonal communication and relationship with nurses than the ages or generations of the nurses, although several participants claimed they were able to better relate with the novice graduate nurse than the "old school nurses" whom several participants saw as highly competent but more likely to be set in their ways and routines.

Within NPRs, the participants' experiences of relationships with classmates on NPRs could serve as a source of support and encouragement, for they were "all going through the same thing" at the same time; alternatively, some participants experienced relationships with classmates as a source of competition for the A grade on the rotation until a pass/fail evaluation system was implemented. The importance or impact of relationships and communication with classmates on NPRs was meaningful to half of the participants in this study.

Lastly, the majority of the participants were aware of their position or status as nursing students relative to the clients and nurses on the NPRs. With their clients, a few participants perceived that they had an authoritative role as a nurse, yet with the other nurses and health care providers, they described themselves as being "on the bottom rung" or relatively powerless within a hierarchical system. Some participants struggled to find their voice to advocate for their clients with the other nurses, yet those who did had felt empowered. They also perceived that they were powerless in disagreements about their clinical grades, for they feared retribution if they questioned or complained about the CEF's judgement. Moreover, some participants saw Course Leaders as powerful or "all mighty gods" who had power over their grades and took the CEF's side over the students' concerns. The ways in which the participants made sense of the (mis)use of their status by nurses on NPRs varied. Some claimed that "being thrown to the wolves" was not a personal attack because the nurses were protecting their clients while others saw the nurses as human and fallible.

In the remainder of this findings chapter, the reader will encounter comments, anecdotes, or stories from the participants as a means of unpacking the above essence of the participants' lived experiences of interpersonal communication with nurses and clients on the NPRs of their nursing education through themes related to the roles, relationships, and statuses. While the

participants' comments illustrate the findings throughout the findings chapter, the themes are my interpretation of their lived experiences and perceptions.

FINDINGS RELATED TO ROLE DEVELOPMENT

Roles

The participants experienced uncertainty about their roles as nursing students which was manifested through their perceptions of NPRs as fearful places in the theme *We Experience Fear*, through their perceived disappointment at being unable to provide the kind of holistic nursing care that they had learned at the faculty in the theme *We Aren't Doing What We Learned at the Faculty*, and through their desire for achievement like that at the university in the theme *We Want the A Grade*.

We Experience Fear

All but one of the participants' (Kathryn) lived experiences of interpersonal communication with nurses and clients on NPRs were fraught with fear because they were new to the nursing role. When the participants first walked into the health care contexts and units of Nursing Practice Rotation (NPR)S, particularly their first or second NPR, they had entered professional and interpersonal environments that were largely foreign to them. Participants described their experiences in these new *lifeworld*s (Habermas, 1997) of different areas of nursing practice as "anxiety provoking" (Aubrey, Jillian), "paralyzing" (Sophie), "scary" (An, Danielle, June, Robert), terrifying (Meredith), and "stressful" (Wren, Lena) despite the fact that they were learning the content of nursing practice relevant to each NPR. In this study, participants consistently reported experiencing significant fear and overwhelm as nursing students on NPRs because they were unaccustomed to the contextual environments of nursing practice and because they had not known how to approach the role and responsibilities of the nursing student in three main ways.

On their first few NPRs, six participants (June, Danielle, Isabella, Aubrey, Jillian, An) experienced fear of the unknown either as (a) not knowing 'how things work around here' or (b) not knowing how the nurses on the rotation would behave towards them. For instance, June and Isabella were unfamiliar with the organization of the unit and the roles on the unit. Growing up healthily in a rural community, June had not been exposed to the large health care facilities of an urban centre, "It was our first day and first day in the hospital...Never been in a hospital before. Don't know what a chart is. Nothing..." (June). Isabella had grown up in the city and was accustomed to being capable, competent, and helpful to others, yet she struggled to determine who and what was important in her first NPRs:

> I didn't know what the unit clerk did, what the role of the unit manager was, I didn't know how the clock of the hospital works. How do you teach someone how to read a call schedule and figure out who you are going to be calling? They don't cover that in a class. (Isabella)

June and Isabella's comments illustrate their feelings of uncertainty and disorientation within their first learning environments of NPRs. Both experienced fear because they were physically (June) and psycho-socially (Isabella) far from home.

Other participants, like Jillian and Aubrey, feared the nurses whom they would encounter on the rotation. As a nursing student, Jillian was concerned about nurse educators, nurses, and classmates' initial perceptions of her and their willingness to teach and learn with her:

> At every clinical rotation [NPR] you go to, you are kinda anxious: it's probably a new facility, it's people that you don't know, you are wondering if they are going to welcome me or if this going to be the unit where I get linked up with Buddy Nurses who don't want to help me, what's the CEF going to be like, and you might not know any of the students in your clinical rotation. So you go into with a level of anxiety because there are just so many new things. And it's a new area of practice that you have never done before. (Jillian)

Aubrey worried if she would work with supportive nurses because she feared that would not be able to manage nursing care on her own. When asked what her NPR had been like for her, Aubrey said:

> If I had to give it one name, I'd say anxiety provoking. If I remember anything from being in school it was being super anxious. Not even for exams but more for clinical. Not knowing what to expect. It was truthfully the people more than anything else. It was fear of who my Buddy Nurse might be tomorrow, or what is my patient load going to be like. (Aubrey)

Jillian and Aubrey's comments are reflective of the participants' anxiety about establishing interpersonal teaching and learning relationships with nurses on NPRs.

Five participants (Robert, June, Jillian, Sophie, Lena) experienced fear on NPRs because they felt ill prepared to manage the knowledge, skills, and interpersonal communication of the nursing role within the NPRs. Robert, a mature student who was accustomed to being flexible in both personal and professional contexts was confused by students' immediate immersion in NPRs, "The thing that really struck me was the first day of clinical I hadn't even had a class yet...so we are literally in clinical but we hadn't had our first class. We are like "huh?" this is going to be interesting. There was no front loading or anything!" (Robert). The participants' most commonly described NPRs was a "sink or swim" situation (June) in which they were "thrown in there" (Jillian). Robert claimed that "It was like: You. [points his finger at me] Deep end. [points across the room to indicate the NPR]. Sploosh!." Several participants, like Jillian who was a self-directed nursing student, reported that they were expected to interact with nurses and clients without formal instruction in communication:

> We weren't really prepared. We are kind of thrown in there. We are kind of expected to figure out how to communicate with the nurses. And I don't think any of us were very good at it right at first. Well maybe a few. A fortunate few. But I found it hard. (Jillian)

Subsequently, Sophie's reaction to being "thrown in" was to freeze:

> It's paralyzing when you feel like you are in over your head. That's kind of, unfortunately, a lot of my memory of clinical practice (NPRs); it was paralyzing. Feelings after the first week were, that's just how it was and just about getting through it, but it wasn't conducive to learning, I didn't think. (Sophie)

Although Sophie had been exposed to several ambiguous situations in her travels to foreign countries, she felt unprepared for the shock of the first few weeks on each new NPR. The responsibilities, knowledge, and relationships of nursing practice were overwhelming for Sophie and she felt "in over her head." She recognized that feeling paralyzed did not facilitate her learning.

Similarly, Lena, a student who had excelled at academics and student leadership, described herself on NPRs as oversaturated by information, busy, frantic, and bumbling:

> What made them [NPRs] stressful for me was the feeling of not knowing something. Not knowing the answer to something because I just didn't know it...feeling like you were looking stupid that you didn't know or making a mistake... but your brain is just full of things that you tried to learn and you are busy doing things in your clinical day: you are trying to build rapport with your patient, you are trying to keep good rapport with the health care aides and the other nurses, trying not to trip over yourself or spill anything on you white uniform. (Lena)

These participants, individuals who were capable in other contexts, felt that the university theory courses or clinical nurse educators had insufficiently prepared them for the realities of the NPR, and they experienced discomfort and stress in communicating with nurses and clients as a result.

Five participants (Robert, Aubrey, Jillian, An, Wren) experienced "fear of making a mistake, by either doing something incorrectly or forgetting to do something that would have a negative consequence to the patient" (Aubrey). To illustrate, Robert stated that, "These are people [the clients]! This is not a textbook. These are people. What happens if your patient goes into cardiac arrest? Ack! You know? This is a scary situation" (Robert). If a client went into cardiac arrest for instance, Robert feared that he would not know or remember what actions to

take. He recognized that their decisions and actions as nursing students had consequences beyond learning or earning a grade.

As Jillian's comment below illustrates, several participants acknowledged that learning about nursing practice on campus with books and through simulated skills lab tasks was incomparable to learning in practice with 'real people' whom they could harm in the process:

> We go out there [in NPRs] feeling really ignorant. You know, we have learned it all in books, and we have done it in skills lab, but a lot of us are scared to death when we actually get out there. People's lives are on the line, and we are terribly scared that we are going to do something wrong... Most students are not confident. Some are just better at faking it than others. (Jillian)

While some nursing students attempted to fake or feign confidence in the face of fear of harming a client, Aubrey's response was to latch on to her CEF:

> My relationships with my CEFs were generally pretty good, but I did kinda cling to them like a safety blanket. I seriously would like to bring them with me almost everywhere I could. I was getting observed on skills that I had done like tons of times, just double checking things that probably didn't need to be double checked. I think it was because it was so anxiety provoking. It was like, 'Okay, if she was with me most of the day, then at least I can sleep at night'. (Aubrey)

While Aubrey acknowledged that CEFs and other nurse educators likely found her approach unnecessary and unrealistic given the needs of other clients and nursing students on a given NPR, Aubrey felt her practice was safer than a nursing student who hid from (avoided) the CEF or who took risks with client care to "fake confidence" as Jillian suggested.

These three main fears are indicative of the participants' overall experience of socialization to professional nursing practice through interpersonal communication on NPRs. The unpredictable nature of nursing interactions caused the participants stress and anxiety because they had a strong desire to prove to themselves, the clients, and the other nurses that they could be good nursing students, and by extension, good nurses in the future. Nonetheless,

the participants in this study had not known how to approach the role and responsibility of the nursing student, and subsequently experienced fear.

We Aren't Doing What We Learned at the Faculty

Nursing education promotes not only the knowledge and skills of nursing but also espouses the values of nurses within their role, and nursing students convey these values through their interpersonal communication if education has been effective. One such value is the practice of providing holistic nursing care to clients. The American Holistic Nurses Association (AHNA) (1998) has defined holistic nursing practice as healing the whole person (client), as the nurse is a therapeutic partner with the patient in recognition of the client's physical, psychological, socio-cultural, spiritual, relationship, contextual and environmental needs. As such, holistic nursing is "an attitude, a philosophy, and a way of being" (AHNA, 2014, para. 5) that is an extension of the caring art of nursing practice. In this study, five participants (Aubrey, Meredith, Sophie, Jillian, and Kathryn) identified that holistic nursing care had been encouraged and valued by faculty members in various theory courses on campus, yet they claimed that nurses inconsistently practiced holistic nursing care on NPRs. These five participants expressed their desire to initiate and sustain holistic caring through interpersonal communication with their clients as part of their role as nursing students on NPRs.

The five participants identified three reasons why holistic nursing care was difficult to practice on NPRs: lack of time (Aubrey and Jillian), high client load and demand (Meredith), and lack of prioritization of holistic nursing practice (Sophie and Aubrey). Although Jillian and Aubrey valued the notion of nurses' helping to meet clients' social and emotional needs through interpersonal communication with clients, they perceived that nurses lacked the time to converse with clients. Aubrey shrugged her shoulders, sighed, and told me, "We always talk about holistic

care [in class at the faculty] but realistically, when you are out there [on NPRs] there is very little time to have a conversation" (Aubrey). In frustration, Jillian claimed that:

> I find the most frustrating about nursing, remember how I told you that I wanted to go into nursing because I wanted to help people?...but as a nurse, you often don't have time for that. You have time to pop in the morphine, but don't have time to [talk]..you have so many tasks. You can get so task oriented. (Jillian)

Jillian's experience of having just enough time "to pop in the morphine" illustrates her concern that nursing practice that is so driven by time as to become task oriented rather than communication and relationship oriented.

While Aubrey and Jillian attributed the absence of holistic nursing care to a lack of time, Meredith claimed that the nurses also experienced high client loads within health care facilities that were ill equipped to manage the public demand for care. Meredith expressed her thoughts with deliberate sarcasm, "They talk about holistic care, but at the end of the day, someone needs a skill and I'm like 'okay, I want to do it!' or 'how many patients can I take care of today?' that must mean that I'm a really good nurse" (Meredith). In this way, Meredith understood that her role as a nurse meant having the skills to get anonymous clients through the health care system as quickly as possible.

Sophie and Aubrey expressed their disappointment and frustration at the lack of prioritization of holistic nursing care in the practice settings of their NPRs. Sophie's priority as a nurse was "helping someone to find a healthy balance. A physical, emotional, spiritual, mental harmony, and find it in different ways. I was also disappointed that I didn't feel that I learned how to do that even though it was valued and something we constantly talked about [at the faculty]" (Sophie). Her expectations were:

> I guess I thought I would have more time with clients, and I felt like I had more time with beeping machines. Not really getting to know the client in their holistic self. I would say

> that was true more on wards, but that's the nature of it because you want to get people through quickly. (Sophie)

As a result, Sophie revealed to me at the time of the interview that she had doubts about practicing as a nurse and was investigating educational programs in holistic medicine. Similarly, Aubrey doubted her ability to practice nursing the way that she wanted to do the job, to "go home feeling fulfilled" because she had related to her clients as individuals in her care:

> And it was busy, and I didn't have time to ask my patient how their lunch was…something like that…or didn't have time to help them shower in the morning and the health care aids had to be delegated that..So it's those days when they asked and I had to say "I'll come and help you in 20 minutes" because there were more critical things going on. Those were the days where I didn't do the job to the way that I wanted it and thought "Is this what I really want to do?." I don't want to go home and feel unfulfilled. The little things would keep me awake at night, like: she wanted help with her sweater and it took me 20 minutes to get back to her…I mean, she was fine, but it didn't match the shoes or something…things mattered to certain people, if you didn't have the time…if it wasn't health related. But I felt that was my role. I was there to help them. (Aubrey)

Sophie and Aubrey saw their role as a nurse as caring for the various needs of clients. When they saw clients' physical needs prioritized to the exclusion of their psychological, socio-cultural, spiritual, relationship, or environmental needs, they experienced disappointment and discouragement as nursing students. In summary, nearly half of the participants perceived that it was their role as nursing students to engage in holistic nursing care through interpersonal communication, but they felt that doing so was challenging within their NPR to the extent that some participants were actively discouraged from communicating with clients in holistic ways.

We Want the A Grade

During the first two years of their nursing education, the participants' performances and assignments on NPR were evaluated by letter grade (A, B, C, etc). In the final year of their studies, the faculty administration changed the grading system on NPRs to pass/fail. The

participants' comments indicate that the change from letter grade to pass/fail significantly altered the way that the participants communicated with each other and with their CEFs. Four participants (Sophie, Lena, Isabelle, Danielle) perceived that the change in grading system had impacted their interpersonal communication and relationships with their classmates and CEFs. When participants were given letter grades for their performance on NPRs, Isabella and Lena argued that the CEFs' letter grading criteria of student performance was largely "vague and subjective" or "unfair." Moreover, Isabella told me that nursing students sought the CEF's attention to prove to the CEF that they deserved a high grade. Lena's perception was that the CEF had power because the CEF distributed the grades/marks that enabled the nursing students to pass the NPR and move forward in their nursing education:

> I often saw a conflict between the students and CEF where there was a disagreement with the student because of the power dynamic. The CEF has the power because the CEF has the marks and because the student is the student. Most students didn't feel that they could talk or communicate what they wanted because it was in contrast with the CEF and they didn't want to fail, and they didn't want the CEF to be mad at them. (Lena)

Their perceptions were that the grading was "unfair" because the CEFs' assignment of grades did not reflect students' abilities:

> I hand in an assignment and someone else hands in an assignment that definitely does a better job than I did. The students will compare with each other what they may have gotten, but the student got the same mark that I did. I found that, especially in some of my groups, there were some really 'type A' kind of people who were like 'I'm all about getting the A', so when those marks were distributed in a way that students felt were unfair, there was a lot of conflict there, frustration. Um...Yah, that's where I saw a lot of conflict. But I rarely saw people speak their minds freely because they often didn't want to offend others or fail. (Lena)

The result, according the Lena and Isabelle, was that nursing students' communication with each other and the CEF was based on a climate of distrust and self-interest because they felt their role was to compete against each other to earn the A grades on the rotation. Moreover, the perception

among some of the participants was that there were a limited number of A grades to be awarded for clinical performance. Lena's above comment suggests that the conflict or frustration about grades among the students was *covert* because the students did not want to offend other students or cause a conflict with the CEF that could lead to failing the rotation. However, Sophie experienced more *overt* conflict among the nursing students on her NPRs due to grading:

> I remember being very...upset by the bullying that would go on between nursing students. Just...The competition. If someone was threatened by someone else getting all the right answers, then they would be talking about them. I just don't like that..I guess that's more gossip but that's conflict too. But I don't like that too. There was some of that. (Sophie)

In sum, the participants' perceptions were that their role as nursing students was shaped by competition for the A grade.

When the evaluation procedures were changed by faculty of nursing administration to pass/fail, the participants' perceptions were that communication and relationships among the students were more collegial and supportive. For instance, Danielle who valued friendships among her NPR student group explained, they felt it was less risky to make a mistake or ask a question:

> Now that it's pass/fail, I think that makes it a lot better for students. Before, when I was doing it, at least until my last term, it was always about marks. So you could see…if you are nicer to this teacher then maybe he/she will give you a better mark. Now that it's about passing or failing, you are either okay or something is going wrong. (Danielle)

Given the reduction in stress among the students to achieve high grades, Lena, a high achieving student with regard to grades, claimed that she and her classmates had asked the CEF more questions and engaged in relationship more frequently with their CEF. She explained that the students' dynamic had changed to the extent that they wanted all of their classmates in their NPR group to pass together, so they helped each other to reach this common goal. Lena explored this change in detail within our interview:

> I was really fortunate to be in the group that went from being graded clinical to pass and fail clinical. Beforehand, there was a lot of this horizontal tension between students where you didn't want to help them out because if you did better than they did [grade wise], there is only a certain number of As in every group, Bs, and Cs. Didn't happen often that you would get a better mark. I think it's really unfortunate in nursing. So I really felt that ease as soon as it went to pass fail. I felt more comfortable helping other people, and more people were more comfortable asking for help...and looking over other people's work. I really felt that was a big change when it was just a pass and fail. You wanted everyone in your group to pass, so you were more willing to help out and do teaching with other students who were finding something more challenging. (Lena)

Thus prior to this change to a pass/fail method of evaluating students' performance on NPRs, the participants' priority was earning the best grades or their role was to be a "type A" nursing student (as Lena named it).

In conclusion, several participants' perceptions were that their role was to earn a good grade on the NPR which, at times, negatively affected their interpersonal communication with CEF and other classmates on NPRs until this evaluation procedure was changed to pass/fail.

Relationships

Participants experienced relationships between: the CEF and nursing student; the client and the nursing student; the nursing student and his/her classmates on the NPR; Buddy Nurse and nursing student; Course Leader and nursing student; and Preceptor and nursing student. Moreover, the participants experienced relationships among nurses within a given unit culture of nursing practice, as well as relationships with younger nurses and more experienced nurses. These varying forms of relationship accounted for a significant portion of the findings in this study. The participants' perceptions of these relationships are explored in this section.

Participants placed significant weight on their relationships with their CEFs. The nature of teaching and learning within the NPR creates and fosters possibilities for close inter-personal helping relationships between a CEF and his/her nursing students due to the (a) limited student to

CEF ratio (6:1 at the time of this study), (b) length of NPR days (two 8 hour days for 6-12 weeks), and (c) the intensity of the clinical setting wherein students are in "intimate and often emotional learning conditions" given the client conditions (Zieber & Hagen, 2009, p. 356). This relationship will be theorized upon in Chapter five, the Discussion.

Clinical Education Facilitators: The Linchpin

In this study, participants perceived that the Clinical Education Facilitator (CEF) was the linchpin, the nurse who has the most prominent relationship with nursing students on NPRs and who communicated most frequently with nursing students in comparison to other nurse-educators or nurses. In this study, participants unanimously described their communication and relationships with their CEFs using language normally reserved for close personal relationships. They spoke of trying to connect, click, and build relationships with their CEFs, and participants' body language appeared animated, appreciative, happy, sad, helpless, or frustrated during discussions about their CEFs. As a result, the themes for CEFS are also personal and emotionally-laden and include: CEFs whom we felt built us up, CEFs whom we felt knocked us down.

All participants reported experiencing inconsistency in relationships and interpersonal communication with CEFs. For instance, Lena, a participant who reported making positive relationships in her personal and professional lives stated that:

> I had a broad range. Different people from different backgrounds with different teaching styles. Some of their...some CEFs I just didn't click with, so those relationships were tougher to maneuver. For example..my CEF was more of a blunt person. Someone who wasn't about the touchy feely kinds of things, so I found that really hard to gauge and understand 'what am I doing right? What am I doing wrong? (Lena)

In other words, Lena felt she had had to learn to adapt to each individual CEF's teaching style, communication, and expectations. Lena had found a relationship easier to maneuver when the CEF's interpersonal communication matched her own communication style.

In contrast, Robert did not assume that *he* should adapt his communication to the CEF because he recognized that some CEFs were "extreme" or unprofessional in their interpersonal communication and approach to teaching:

> The CEFs, each one was different. You had the ones where, it pretty much didn't matter what you came to them with, it was all good. Then you had the ones [CEFs] where, they were really intense. Like my last CEF, she was really intense. I was like...really?...She really needed to tone it down a few notches...There is the CEF that is so laid back you essentially find him sitting with his feet up on the table somewhere playing video games. Not really appropriate, but you know…he's laid back. And then you got the one [CEF] who is constantly over someone's shoulder. Either one is an extreme, you know? I like the middle road. I like the ones who stayed on the ball but weren't hovering. Helicopter teaching doesn't help anyone, in fact, it can make people really nervous. (Robert)

Thus, Robert had experienced CEFs who were open and receptive, serious, disinterested, and hypervigilent in their interpersonal communication with their students. Similarly, Wren had experienced differences in nurses' approach to the CEF role, "Some were good. Some were not good....there were extremes. Some were very distant, and some were more connected" in that some CEFs valued relationships while others did not (Wren). Jillian was also critical in her appraisal of CEFs' perceptions of their role and relationships. According to Jillian, some CEFs trusted nursing students from the start of the NPR while other CEFs wanted students to earn their trust:

> As long as you are being consistent and working hard, she had it in her head that you were a fabulous student. Kind of like the innocent until proven guilty kind. Whereas some of them [CEFs] were like the guilty until proven innocent kind; you are all kind of idiots until you can somehow prove to me that you are not. (Jillian)

Thus, participants had experienced CEFs with a range of approaches to the CEF-nursing student relationship in terms of communication, expectations, and professionalism. However, it was not knowing what to expect from each new CEF that contributed to participants' fear on NPRs.

Conversely, some participants considered themselves "lucky" (Sophie) or "fortunate" (Lena) to have had positive relationships and communication with CEF, a viewpoint formulated through their own experiences with CEFs (Aubrey, Jillian, An) and in talking with other nursing students about their experiences with CEFs (Danielle, Meredith). As Meredith said "Nursing students love to talk about clinical [NRRs]!" The next two themes, 'Our perceptions of CEFs whom we felt built us up' and 'Our perceptions of CEFs whom we felt knocked us down' provide deeper insight into the participants' perceptions of the range of experiences of relationships and communication with their CEFs.

CEFs whom we felt built us up. When participants described their experiences of positive relationship and communication with their CEFs, they described these CEFs as pulling on their strengths and seeing their potential (Sophie), giving them confidence and positive reinforcement (Jillian, Meredith, June), and providing useful feedback (Danielle, Meredith). They saw these CEFs as supportive (An, Meredith), competent (Robert, Sophie), trusting, open and positive (Danielle), and, helpful (June).

CEFs who the participants perceived built them up had positive attitudes about nursing and nursing students. The participants claimed that these CEFs encouraged communication and modeled effective communication with clients so their students could learn. For instance, Sophie and Meredith reported that they had had CEFs who saw them as learners who needed opportunities to practice, reflect, and grow. Sophie's claimed that:

> She [her CEF] helped me see myself in a different way. I would say that her communication with clients was very honest, and she kinda just laid it all out there... I

> just really appreciated how she used her compassion at the forefront...and by believing in us and seeing the potential in us and what we could be, because in second year, I didn't feel like I was there. But she kinda saw the bigger picture. I really appreciate that. (Sophie)

In this way, Sophie felt her CEF had used her experiences of communicating and relating with clients to be honest with her nursing students about their capabilities as nursing students. Moreover, Sophie claimed that the CEF "saw the bigger picture" or had perspective on the potential of her students. In a similar way, Meredith had a CEF who was "like no CEF I have ever had" because he communicated "about every situation" and debriefed with Meredith after client encounters:

> After, he would always debrief, and some of them [CEFs], they don't do that. But I told him at the beginning, I communicated to him that I like to debrief after things because I like to know how I'm doing. I need that. And by fourth year, you already know that you need to communicate with your CEF; that's how we are going to have this kind of relationship. So we would finish a skill or an interaction with a patient that he would be present for, and say "I felt this was a good thing" and he would point out things that I never would have…he just built me up. You know, he would say "You handled that so well. You showed so much confidence." And I would say "Really? Because I felt so nervous inside!", yet he said "No! You did it so well!." He always had positive things to say, even in the negatives. He's like "You know what? This is an area to work on, and it just takes time. (Meredith)

By her final year of nursing education, Meredith told me that she knew that the relationship with the CEF was integral to her growth as a nurse and sought a relationship with her CEF that was honest and open; her CEF had met that need. Both Sophie and Meredith had responded positively, not just to *what* feedback was given, but to *how* that feedback was given. Sophie and Meredith perceived that the CEFs who framed his or her feedback (negative or positive) within a belief in that student's potential ("it just takes time" or "she saw the bigger picture") gave them confidence with a skill or communication.

The CEFs whom the participants perceived to have built them up were competent nurses who communicated support for and trust in nursing students. Robert was "impressed" with a knowledgeable CEF who helped them care for their patients, yet "she was always without a hair out of place, you know? I thought, 'that's interesting!" In other words, Robert had perceived this CEF to be competent at balancing the care of the clients and the learning needs of the students. An, the participant who struggled with English as an Additional Language throughout his nursing education reported that the "nice" and "helpful" CEFs were "supportive with where I came from and helped me the best they could to get me through the course." In spite of An's less proficient English, he felt valued as a nursing student. Sophie appreciated her encouraging CEFs, "ones who would pull on my strengths and then say what the "work on" things were. I really appreciate that. I think that's a very effective way to communicate and to believe in someone's potential. Generally, I'd say that quite positive" (Sophie). For Sophie, these CEFs gave her opportunities to use her talents and abilities (i.e.: pull on my strengths), yet gave her concrete and realistic feedback. For Danielle, the CEF who "put trust in you", by making statements such as, "You [Danielle] can drop the medications. I've seen you do it twice and you've done a great job" gave Danielle confidence. Therefore, Robert, An, Sophie, and Danielle's communication and relationships with these CEFs whom they viewed to be competent, supportive, encouraging, and trusting CEFs helped them reach their potential and facilitated their socialization to nursing practice through positive relationships and interpersonal communication.

CEFs build up nursing students by building community among the group of students on the rotation. One of Danielle's CEFs gathered her students together at the end of a clinical day and "She really helped us prioritize things, and she would challenge us to things…she would pick some sort of topic, and make us explain about it. I thought that was really good; something

about the day that she could incorporate into the topic. Yah. She was very good. We could go to her if we ever had any questions or concerns. She was just open and positive" (Danielle). Similarly, Isabella's CEF "…got us to work as a team and help each other out. If you were slow, you were to go help out the other nursing students. I don't think any other CEF had enforced that team within a team" (Isabella). Stated another way, CEFs whom Danielle and Isabella saw as creating relationships among nursing students, helped them to fit into the unit as a team and help each other care for the clients on the unit, not just their assigned client(s). Both Danielle and Isabella value helping and supporting their fellow nursing students, so it is unsurprising that they identified CEFs who built community among the nursing students through communication.

CEFs whom the participants felt built them up helped nursing students manage relationships with other nurses on NPRs. June recalled a CEF who "was onboard with [her]. She was totally supportive. That was really helpful" when June fulfilled a dying client's wish to get up, despite her Buddy Nurse's repeated discouragement. Jillian praised a CEF who "went to bat" for her (Jillian) by defending Jillian when another nurse was misinterpreted Jillian's remark about her. Stated another way, the participants described CEFs as protecting their nursing students by helping them to negotiate their first experiences with conflict with other nurses on NPRs which helped them to learn to communicate with other nurses.

Thus, participants who viewed their relationships with CEF as positive felt they were engaged in a caring teaching and learning relationships that were fostered and maintained by positive interpersonal communication. As students, they felt safe learning within complex health care environments because of the communication and relationship with these CEFs to the extent that the participants (Sophie, Robert, Danielle, An, and Meredith) appreciated and admired positive CEFs and strove to emulate them.

CEFs whom we felt knocked us down. The participants' also had interactions with CEFs whom they experienced as ineffectual in relationship and interpersonal communication. Nine participants (Aubrey, Jillian, Isabella, An, Sophie, Lena, June, Danielle, Kathryn) claimed that these CEFs inhibited their learning of interpersonal communication with nurses or clients, or "knocked them down" as novice nurses. The participants' reactions to being knocked down were personal and emotional in the language they used; moreover, their body language conveyed anger, sadness, annoyance, and bitterness toward these CEFs. They described relationships with CEFs wherein the participants felt the CEFs: were out to get them (Aubrey), pick at their faults (Jillian), pick on them (An), set them up for failure or blame them if anything went wrong (Danielle), and gave unhelpful feedback (June). As An stated, "Work hard. Not all [CEFs] will support you. Generally, people are helpful and some people will pick on you. You have to be aware that it's not always a smooth and straight line" (An). In other words, An felt that nursing students must be prepared to encounter CEFs who make NPRs difficult experiences for their nursing students.

More specifically, Isabella, June, and Lena felt knocked down in that they were ignored by CEFs who were absent or distracted during the NPR. Isabelle had "a CEF who would disappear from the hospital for hours at a time. No one knew where she was" (Isabella), and June's CEF "was never really around" (June). When I asked them where the CEF had gone, neither participant knew. One of Lena's CEFs was a nurse from a busy hospital medicine unit yet taught nursing students in a geriatrics rotation in a personal care home. Lena perceived that her CEF lacked interest in gerontology, and her lack of "joy" was transmitted to Lena and her clinical group:

> There wasn't a joy there. I think, and the joy for geriatrics wasn't there, so I don't think any of us as students got to see the positives, you know, that you can have from that type

> of nursing. And, it's not really as exciting as say, trauma bay for example, but it has its own joy. It has its own excitement and value. It's just as important. (Lena)

Similarly, Isabella had one CEF who had accepted a CEF position "as an interim thing" as she was starting a new position the next semester, so the CEF:

> …literally talked about herself for 8 hours in our clinical experience. We would sit there, and literally listen to her talk about herself for 8 hours. We never had enough time to complete our projects there because she was always talking about herself. I don't think I learning anything in that clinical rotation. (Isabella)

Because of the CEF's position of power, Isabella told me that she and her classmates had listened to this CEF talk about herself rather than focus on their project work. June, Isabella, and Lena's anecdotes indicate that in these instances, they felt that they were not given the opportunity to engage in effective and meaningful communication and relationship with these CEFs as part of their learning. In the absence of guidance, coaching, or instruction from the CEF, June, Lena, and Isabella perceived that they were responsible for learning to communicate with their clients and the other nurses on these NPRs.

Sophie and Jillian felt knocked down in that they were threatened by CEFs who were dominating and who hovered over them. Sophie, who had chosen to enter nursing so she could use her strengths of compassion and caring, was threatened by a "quite dominating" CEF who:

> I think [put] a lot out on the line before I was able to absorb it all. Just with expectations. I never found that helpful. So I would say that was a communication technique that had a negative impact...Just kind of throwing so much on the table in the first week of clinical, and you can't quite figure out how you will get there. Just doing gradual steps is good for me. So that was her technique and that just added to the whole stress of the situation...that was a stressful time. (Sophie)

Stated another way, Sophie did not respond well to the CEF's "technique" of overwhelming students so they scrambled to "figure things out" by the end of the rotation. In contrast, the CEF that caused Jillian the most stress:

> was the CEF who decided that I was anxious about clinical and told me that I was anxious about clinical.... she thought I was taking too long, and I wasn't being efficient because I was anxious of making a mistake. And thereupon she proceeded to tell me several times that I was anxious and then lean over my shoulder, which kind of made me more anxious! [laughing]. There is nothing quite like being told "You seem really anxious today" and to have someone lean over your shoulder...um, yah, now I am! [laughing]. (Jillian)

In this instance, Jillian had understood that she was not to be trusted in her care of the client. In contrast when Sophie felt overwhelmed by the amount of information from her CEF, Sophie felt that her CEF had overestimated her capabilities as a learner.

Whether the participant was the target or the witness of communication by CEFs that knocked them down, the consistent result was painful and confusing feelings of doubt, lost confidence, anger and upset among the participants. Aubrey had witnessed CEFs interact with other students and "Sometimes, I felt like they were kinda out there to get them...it was awkward" (Aubrey). Aubrey was a conscientious and hardworking nursing student who relied on her CEFs because she was so anxious, so she felt conflicted at witnessing such interactions. Danielle who had developed close friendships among her fellow nursing students became upset upon seeing classmates suffer in relationships with their CEF:

> It wasn't me that I actually had any problem with the CEF but it was everyone around me, and I could see it. I was kinda like the witness to everything that was going on around me. It just made me feel upset about it even more...seeing the students with me going through things like...it almost seemed like the CEF was trying to set the students up for failure. Like a student that I knew and I'd had a rotation with prior and who was a very good student...the CEF would ask the student to do something that another student had, and if something went wrong, it was always the blamed on that student. It was just ridiculous. (Danielle)

On behalf of the students, Danielle had spoken to this CEF in private and explained that she and her classmates felt the rotation was not going well due to the CEF's expectations "that have nothing to do with patient care and learning" (Danielle) Prior to the rotation, Danielle had "heard rumors" that nursing students had to speak up to this CEF or she was "terrible" (Danielle). Thus,

Isabelle, June, Sophie, An, Jillian, Lena, Aubrey, and Danielle directly and indirectly experienced negative CEFs' communication and relationship.

Participants such as June and Kathryn felt that CEFs knocked them down when the CEFs lacked transparency about their progress or grade on a NPR. Kathryn had the impression from her CEF interactions that she was doing satisfactorily on her rotation, "I passed, but I came to find out later that I almost didn't pass! But it was after the fact...and it was over! I didn't know that until after it was over, so I really would have appreciated more feedback because saying 'everything is fine" and it's not fine? I don't like that" (Kathryn). In other words, Kathryn felt that her CEF failed to communicate (or knowingly withheld) information about her performance on the rotation at the time when Kathryn could have taken actions to improve her client care and progress as a student. June also experienced this shift in the CEF's opinion about June's performance evaluation, "I disagreed with something she said, and I asked her about it. She made some excuse like, 'Oh, I was tired when I did this evaluation'. I was like, 'Okay....' (June). June had understood that her progress is neither important nor worthy of this CEF's energy. Unsurprisingly, Kathryn and June did not trust future CEFs as easily after such encounters.

In summary, the theme of the CEF whom the participants perceived to have knocked them down demonstrated the participants' negative perceptions of their relationships with CEFs, discouraged the participants and undermined their confidence to communicate with clients and other nurses. Several of the participants perceived that some CEFs lacked interest in teaching, lacked judgment, and suggested that CEFs had misused the power inherent within their position.

Some participants' (Danielle, June, Lena, and Isabella) claimed that their experiences of relationship and interpersonal communication with CEFs influenced their perceptions of areas of nursing practice and their future careers as nurses. More specifically, if a participant had

experienced a positive relationship with a CEF, this participant was more likely to choose this area of practice for the Senior Practicum Rotation and was more likely to want to work in this CEF's area of nursing practice. For instance, Lena who saw caring as an essential part of her identity and nursing as her calling stated that:

> The CEF makes all the difference. I really do think so. I think there are some CEFs who are able to inspire students and bring across their love for what they are doing.... I think also CEFs and Preceptors can really inspire and guide people in what they want to do. If you had a really great preceptor in maternity for example, then you might end up there.. So CEFs not only shape your experience, but also where you end up working. (Lena)

Therefore, the relationship and communication between Lena and her CEFs had considerable influence on her perceptions of the intangible rewards of nursing care. Lena had had CEFs who "inspired" her and evoked a "love" for a way of practicing in particular area(s) of nursing that impacted her future choices as a nurse.

In contrast, if a participant had experienced negative relationship and communication with a CEF, this participant was less likely to choose this CEF's area of practice for the Senior Practicum placement or first job as a graduate nurse. For example, Danielle and June had experiences with CEFs that shook their confidence and discouraged them from pursing a particular area of nursing. On Danielle's surgery rotation, the CEF had expected her students to memorize medication information and recite the information when called upon, to the extent that students were more concerned about the memorization of facts than client care. The experience had a negative impact on Danielle and her perceptions of surgical nursing:

> After coming out of that [surgery rotation], I never felt as...like I was always paranoid and I just didn't feel right...I think that's why I didn't like surgery at all because of that. It still stuck with me, and I'm still not interested in it. (Danielle)

At the time of the interview, Danielle had completed her surgery rotation a year and a half prior, yet she spoke of these experiences on the surgery rotation as if it had occurred recently. The

experience had indeed "stuck with" Danielle and had a lasting impact. Similarly, June's maternity rotation had left her "terrified" because she was unclear of the expectations of her CEF whom June felt placed her into client care situations that she was not prepared for:

> After that [maternity rotation], I was terrified of maternity and...just because it was so...I just felt so lost all the time. We had 6 or 8 hour shifts...maybe 6 hour shifts in the hospital and every time, okay what are we going to do? What am I going to have to know? …she was like "Do this. This is you." She never gave us ways for how we could improve, stuff like that. And after that I was terrified, I was like "Oh, I don't think I would ever do maternity nursing again. (June)

The comments from Danielle and June communicated their perception that they were making a conscious choice about the kind of nurses they wanted to become in their professional lives, for the underlying tone of their anecdotes was 'if that's what surgery/maternity nurses are like, I don't want to be one'. These participants had equated a negative experience with a CEF in an area of nursing practice as representative of nursing in this area of practice.

In this study, CEFs were described as the linchpin on NPRs in the participants' experiences of relationship and interpersonal communication in nursing. The participants' stories and anecdotes described their experiences of CEFs whom they felt: built up their confidence and helped them improve their care, knocked them down by their absence or misuse of power, and inspired or terrified the participants about different areas of nursing practice. All of these experiences with CEFs were manifested through CEF-nursing student relationship and interpersonal communication. Furthermore, these lived experiences felt personal for many of the participants. The participants' words covey their emotional responses to the ways in which CEFs shaped their first identities as nurses.

Clients: The Em[Body]ment of Nursing Care

The participants in this study also constructed their nursing student identities through relationships and communication with their clients. To the various participants, the client

embodied or gave form to different meanings of nurse-client interpersonal communication and relationship. Moreover, the participants' views did not always match the nurses' perceptions of communication and relationship with the client. Participants' stories and anecdotes of their relationships and communication with their clients yielded five themes. Five participants described their first fearful attempts to communicate with clients in the theme 'Falling back on our life experiences'. Eight participants spoke of their observations of nurse-client communication in the client themes: 'Watch and learn', 'Positive role models of interpersonal communication', and 'Negative role models of interpersonal communication'. Lastly, six participants spoke of their search for professional boundaries with their clients through communication in the final section 'Boundaries with clients?'

Falling back on life experiences. The participants' perceptions of the importance of interpersonal communication with clients can be summarized in Danielle's statement "if you are not a people person, then you won't like nursing. You have to talk to your patients", yet in ten participants reported that they had been expected to communicate with clients following with little to no coaching or formal instruction in interpersonal communication. As a result, most participants initially saw communication as a set of skills that they had to acquire to introduce themselves to the client, ask questions, clarify information, listen actively, and provide basic health information with the accompanying body language and demeanor of a nurse. These participants had grasped for the exact language, in the form of words, phrases, or behaviour that enacted nurse-client communication during the NPRs. For example, Wren and Danielle had not known how to communicate with the clients; they initially lacked the interpersonal communication skills necessary to the nurse-client interaction. Consequently, both Danielle and Wren told me that their first attempts to communicate with clients in NPRs were fraught with

fear and apprehension, and they required encouragement from other nurses or students to approach the clients. Wren, an introverted nursing student described her first client interaction as nerve-wracking and fearful:

> I remember the first patient I had. I was so nervous to even go in the room because again, you are walking in blind and meeting this person that you don't know. It's such an intimate time in their lives. I remember standing outside the door and like, having to take a minute. What actually got me through that was another one of the students who was one of the moms who was much more comfortable with dealing with people, she went in with me. And then it was fine...you have to very quickly ascend to a very intimate level of communication with them. (Wren)

Wren was afraid to enter the "intimate" live of another person, so she had hesitated on the threshold of the client's room. As a young woman a few years out of high school, Wren told me in a confessional tone that she was unaccustomed to communicating about intimate matters with individuals with whom she had not built a relationship. Danielle relayed to me that she felt similarly unprepared:

> I remember how on my first day, [the nurses] were like "Here's your patient", and I was like, "Oh, how is that supposed to work?" Like I don't know! And she was like "Just comfort the mom" because at that point, we are not at that point in the skills lab where we could do anything really. We hadn't had a day of skills. So she [the CEF] just said comfort the mom with encouraging words and just be there, be there. And it worked! I was so scared, but it worked. [laughing]. (Danielle)

Danielle experienced panic because she had not had a lesson in the skills lab preparing her for such an encounter with a client. However, Danielle had learned in the moment that her presence and "encouraging words" was part of interpersonal communication in nursing care. In these ways, Danielle and Wren learned to initiate communication and build relationships with clients through a process of trial and error.

Unsurprisingly, Danielle and Wren felt unclear and insecure in their role as a nursing student due to the lack of formal instruction in interpersonal communication. As Wren explained:

> I remember the first, in the geriatric rotation, the very first patient that was assigned to me, I just remember having no idea how to approach the role. And I remember standing outside his room, and of course he had all these communication difficulties like dementia, but there was nothing that we could say to each other and I didn't know what I was supposed to be doing. I didn't really have a role. As a nursing student you often don't. It was very awkward. (Wren)

Wren acknowledged that she had not had relationships in her life that gave them any point of reference or intuition on relationship and communication with an elderly person who depended on the care of nurses. She told me that "When I started [nursing education], I was so inexperienced with anything. I had never had any official work positions in high school. I went through high school very quickly...I did about half my courses through correspondence. …And the first year [of NPRs] was very hard" (Wren). Therefore, the combination of lack of instruction and lack of life experience was detrimental to Danielle and Wren's first experiences of interpersonal communication and relationship with clients in their care.

Other participants like Isabelle, June, and Robert recognized that they could draw upon their own life experiences of communication and relationships in other personal and professional settings as a guide to direct them into their first client encounters. As a result, these participants had experienced less fear and apprehension when approaching clients and building rapport. Although June was only twenty years old when she began her NPRs, she had previous experiences in leadership roles as a lifeguard and a swimming instructor that she saw as advantageous in communicating and establishing rapport with clients:

> So the beginning was the maternity rotation and it was a bit scary because we had never even been in a patient's room before, we were sent off to go, and was I supposed to say "Hi. How's everything going?" I dunno...we just didn't know. And we were never told! So that was kind of scary. So we just went in and...and I dunno, I've done lifeguarding and some teaching swimming and stuff like that so I have a little experience talking with people, so I was comfortable with that. But I know that my partner, she was my partner

> for the home visit in maternity, she didn't have any experience in that sort of thing, so I remember that I did a lot of the talking. (June)

While June experienced some of the same initial apprehension and fear as Danielle and Wren, she drew upon her experiences "talking with people" as a lifeguard. In fact, June was able to cover for a fellow classmate who lacked prior life experiences that facilitated interpersonal communicating with clients. Like June, Robert recognized that his life experiences as a mature student were an advantage over the younger students:

> I felt sorry for the other nursing students who were younger because I could fall back on my life experience. I mean, I went in and I was 41 year old. I had spent a year. No, a year and a half in customer service, and had made all my mistakes already, you know….Even right from the start, I could build a really good rapport with patients, and I felt really lucky in that respect. If I were 18, I would not have been as easy. That was never a problem, communicating with patients and building a rapport with them. (Robert)

In his forties, Robert had both personal and professional experiences that allowed him to feel comfortable communicating and building relationships with clients. As an Aboriginal nursing student, Robert "automatically [tried] to delve into [Aboriginal clients'] backgrounds. Their past. The things they have been through…I can bring my own life experiences and my own history to theirs….It allowed me to see what they had been through, and sometimes to read between the lines of things they don't want to share" (Robert). In this way, Robert knew he had had insight and understanding that, not only many nursing students lacked, but also many White nurses did not possess.

Like Robert, Isabella had also worked with customers in retail stores before she entered nursing education, a role which necessitated approaching customers, providing information, and negotiating customer concerns. However, Isabella's work experiences with the public had taught her that communication was not simply as skill for building and sustaining relationship. Isabella told me that she had learned that individual customers or clients lead unique interesting lives:

> I worked retail for a number of years before I went into nursing, so I think you just learn how to talk to people as people…Older adults have really interesting lives, especially when they don't have a lot of family members and they are very lonely. You sit there talking to them, which is pretty much all you can do because it was our very first rotation. It was so valued. Me giving 15 minutes of my time was like the best thing in the world! Where else do you go where you just being there is like a gift? (Isabella)

While Isabella had not yet learned to read a chart or administer medications for her elderly clients, she valued talking with her elderly clients if they expressed loneliness or other emotional needs. She could identify their psychosocial needs for companionship.

Robert and Isabella identified that they brought their identities into their interpersonal communication and relationship with clients; Isabella "cares about people's lives" and "enjoys their lived experiences" while Robert identified with many of his Aboriginal clients and anticipated some of their needs while in his care. These aspects of interpersonal communication were unavailable to younger or less experienced nursing students.

Watch and learn. Over the course of NPRs, all 12 participants claimed that they were able to improve their communication by observing the other nurses interact with clients. For example, Wren, one of the participants most intimidated by interpersonal communication with nurses and clients, stated that "I learnt the brunt of my basic communication skills from watching CEFs and staff nurses interact with patients and each other" (Wren). In this way, the participants perceived that they had learned about nurse-client communication and relationship inductively by observing patterns. Moreover they claimed that they drew conclusions about whether a nurse's communication was positive or negative. To illustrate, Isabella told me that she had learned as much about nurse-client communication from observing what she saw as negative nurse-client communication as she did from observing positive nurse-client communication:

> I think watching nurses communicate with patients and seeing what not to do often. That was a big one for me. What I didn't want to do…then when my grandfather was in the hospital, just watching how different nurses took care of him….which ones made his day

> better and which ones made his day worse. And then copying or avoiding those techniques. I don't think we ever [learned communication techniques/how to talk to patients], not in clinical. I don't remember anything in theory courses about how to talk to patients. I think it was a lot on your own. (Isabella)

Given that Isabelle was not formally taught techniques for communicating with clients, she learned by observing and mimicking language and behavior which she judged to be professional nurse-client interaction.

June claimed that the only way to learn to communicate as a nurse was to be immersed in the nursing practice settings, "I think we did a lot of observation on how the nurses communicated with clients...observing how they talk...And that comes from just being there. I mean, you aren't taught that; we weren't taught that. You need to know how to pick it up..." (June). In a similar way, Isabella learned "on her own" by sacrificing her break times to hear nursing report, "Just listening to a report over and over and over again. Not taking my break so that I could listen to the nurses give face to face report at the desk, so I know what's important and what's not, and why we emphasize this and not that" (Isabella). Both June and Isabella identified that they had taken the initiative to pick up communication with nurses and clients.

However, nursing students like An, for whom English was a barrier, experience more difficulty "picking up" nurse-client communication on the unit in the absence of formal instruction. In An's experience, the "[CEFs and nurses] see that you don't speak English at the same level, like fluently like the Canadian-born, they are marking you already, and say 'you may do well, or you might have to drop the course', so I felt sad. Disappointed" (An). An felt "marked" by the other nurses due to his English language abilities which impacted his confidence and inhibited taking risks to try new language on the ward because the stakes were too high. He felt he also felt he was "marked" by the nurses because he was under the impression that incorrect communication could cause him to fail the rotation.

In summary, the participants' perceptions were that they had to take responsibility to fill a gap in their nursing education by looking for models of nurse-client communication. While each participant took their own initiative, skills, and time to learn to communicate effectively with clients, some participants had a clear advantage over others on the NPRs.

Positive role models. When participants identified CEFs or nurses whom they viewed as a positive or effective model of communication, they admired and (subsequently) attempted to emulate these nurses. To the participants, these nurses indirectly demonstrated the importance of interpersonal communication as part of nursing practice. Despite being eager to learn new nursing skills, Danielle reported that her CEF "made us realize that it [nursing] is not all about putting IVs in or doing catheters. It's about getting to know your patient and providing the best possible care based on their needs" (Danielle). In other words, Danielle had learned that relating to the client and tailoring nursing care to varying needs (physical, emotional, social, etc) of the clients is part of the role of the nurse. Moreover, Wren identified that it was the "more connected CEFs" who "were generally better models of communication for building relationships with patients" (Wren). It was the CEFs who saw nursing as a partnership between the nurse and the client that Wren had wanted to emulate in her nurse-client communication.

More specifically, nurses whom the participants identified as good models of communication empowered the students to listen to clients, respond appropriately to clients with communication deficits, use touch, and manage their own emotions as nurses. Sophie, a participant who valued compassion in nursing care, learned to listen to clients from a nurse who "would even sit back and listen to the nurse before continuing with her communication, so she had a way of taking in all the information, asking the right questions, and going from there. It immediately made me feel confident as I thought "Okay, I can see myself in that role" (Sophie).

In this way, Sophie could reconcile her values as a person with her practice as a nurse which was important to Sophie. In contrast, June learned how to respond to clients who "are saying things that don't really make sense or that you don't really know how to respond back to" through observing the nurses relate to clients in ways that promoted clients' dignity (June). Kathryn, a participant who saw her role as protecting clients was pleased to learn that managing her emotions in the role of the nurse meant she could cry with her clients, "CEF; she was awesome! She taught me that I could cry with patients. It was okay to cry with patients" (Kathryn). Lastly, Danielle's experience was that her CEF taught her that touch and compassion were part of communication in the nurse-client relationship, "She showed that touch and compassion. Sometimes, you don't even need to say anything, just hold someone's hand, right? The non-verbal communication and it changes their experience. I saw a lot of that with her too. Just comfort" (Danielle).

Thus, nurses whom the participants perceived to be effective models of communication indirectly taught them not only the importance of interpersonal communication in nursing practice but demonstrated how to enact communication with clients. These nurses empowered the participants to communicate with clients in verbal and non-verbal ways.

Negative role models. The nurses whom the participants identified as negative models of nurse-client communication were seen as task oriented rather than caring, impersonal rather than building relationships with clients, and lacking respect for the dignity of the patient. Half the participants reported being discouraged by CEFs or nurses from relating to the clients as people (An, Aubrey, Isabella, Wren, Kathryn, June, Wren). For the participants, these nurses created a clinical environment in which it was inappropriate or unimportant to communicate with clients in caring ways. For instance, Kathryn, who valued getting to know clients and believed that

"communication is, your hearing might not be good and your vision might not be good, but you can always feel. I shouldn't say always…but generally you can feel me holding your hand. And...that human contact is huge" (Kathryn). Kathryn had experienced stress and confusion in an interaction in which she was holding a palliative client's hand and reassuring a client when:

> my preceptor said 'what are you doing in here? You know that we don't have time for that. She is dying and there is nothing we can do for her. She is dying. She's uncomfortable. We can't make her comfortable, and we just don't have time'. To me, we certainly do have time. We have to have time for someone who is at that stage. Even if it's just 5 minutes to talk. (Kathryn)

From this interaction, Kathryn had understood that clients who would not recover are not "worth" their time and effort to communicate and to build relationships, so Kathryn saw the nurse as task oriented and impersonal. Similarly, Wren told me that she had become upset when she had a CEF who was:

> not a great communicator and had sort of different ideas about some of the relationship stuff than I did. One of the student's patients died and she was not supportive at all, knocking it down and hindering any communication about it. Basically, you shouldn't show any emotions with the family which you had gone through this [death] with. (Wren)

To Wren, the CEF's lack of recognition of the impact of the death on the client's family and on the nursing students who had cared for the client was evidence of negative interpersonal communication. Although Wren had struggled to build relationships with clients during her nursing education, she valued nurse-client relationships and looked to nurses to help her relate to clients.

For Isabella poor or negative nurse-client communication compromised the dignity of the client. Isabella had seen nurses "talk over" clients as if the clients were not present as these nurses provided their care, "We see people talk over people [patients] all the time, even when the patient is awake and alert. Why are you talking about your break schedule if you are changing someone's pad? That's like a very personal thing, and you are kinda removing their dignity by

doing that" (Isabella). To Isabella, nursing was about helping people not only about performing tasks.

As the tone of the above comments indicates, several participants in this study experienced these encounters as confusing and frustrating because they perceived that these nurses were behaving in ways that were contrary to the participants' perceptions of appropriate nurse interpersonal communication and relationship with clients. They experienced these encounters as discouraging and upsetting.

Boundaries with clients. In learning to establish professional boundaries with clients through communication, participants made conscious choices about how close they would allow themselves to become with their clients. Six participants (Danielle, Kathryn, Lena, Aubrey, Robert, and Isabella) articulated these choices in the interviews.

For Danielle and Kathryn, interpersonal communication was a means of "opening your heart" to clients (Kathryn) as they cared for their clients as they would family or loved ones. Danielle stressed the importance of having "...just have good communication with your patients and treat them like they are family, right? That's what you have to do. A lot of them are scared too. A lot of them like in gerontology and in palliative care, there is a home feeling, but they are scared too. .. All of my patients have been amazing and they have stuck with me…" (Danielle). To Danielle, the responsibilities of the nurse include communicating that clients can be at home in the facility or hospital. It is a 'home' where nurses and clients "stick by each other" or support each other as family would. In a similar way, Kathryn, "loved" that she was able to make her clients "happy" as she would a family member:

> Because I literally love them. So I know when my residents die now, I will cry, and that's okay…I willing to experience sorrow with them or cry with them… to love them... because you do not have the walls built up. I don't know if I would be able to love my residents now as much as I do, if I hadn't had this experience of a CEF who said it was

> okay to cry with a patient…With communication, I think if students could just stop and think, 'if this was me in the hospital or if this was my parent in the hospital, what would I want them to say to me right now? (Kathryn)

In contrast, Aubrey and Lena struggled to balance the clients' expectations for closeness against their own emerging sense of personal and professional boundaries as a nurse. Aubrey explained the expectations of clients for communication in her rural nursing placements:

> And in rural [nursing], they [the clients] already knew who you were before you went into the room. I would go in and introduce myself to the patient like I normally would, and the patient would be like, "Oh, I know who you are! You know this person, and how are they doing?" And then sometimes you wonder "Are you [the patient] telling me everything you are feeling because you know my family?" You worry a lot more about whether they are worried about their confidentiality. It's hard. And visitors would come, and they would ask you "How is that person they know down the hall doing?" and of course they knew that they were there, so you got used to using the same responses like "I can't share patient information. Maybe you could talk to the family cuz they are down the hall..." Because they all know each other. Visitors would come in the evenings and go to four different rooms. They would walk from room to room and say hi to all their friends, neighbours, or acquaintances. (Aubrey)

These experiences in a rural hospital challenged Aubrey to set boundaries with not only her clients but with her clients' families and neighbours. Aubrey had requested this placement because her own family lived close to the town, but she had not anticipated that she would have to communicate so carefully to preserve the confidentiality of her clients and protect her trustworthiness as a rural nurse. Lena had experienced a similar difficulty in communicating with her clients in her urban placement in that she felt her clients were seeking a closer interpersonal relationship than she could provide:

> I find I'm often someone who makes positive relationships very quickly but for me they are somewhat surface. But I find for my clients, they feel like there is more there and that gives them a sense of security or comfort or something like that. But um, I think that in itself is a challenge because...I think it is important to really create a relationship with somebody or to have them feel this is more than just a normal relationship because there is just so much emotion going on there. But if you as a nurse go in and you create these

> deep meaningful relationships for yourself with every patient, you can't do that for a very long time. So, for me, those are the kinds of relationships I'm in. I try to...the relationships that I try to make are non-confrontational and try to understand where you are coming from. Be helpful and still have professional boundaries there.... (Lena)

Lena saw that some of her clients "feel like there is more there" because her clients often believed that their relationships with their nurse, Lena, was as meaningful for Lena as it was for them. In reality, Lena did not hold the same feelings for her clients, but allowed her clients to believe that she did. Lena was uncertain if this circumstance was deception with her clients or self-preservation in her role as a nurse. She saw the value in allowing clients to believe that "there is more there", yet she felt she could not have "more than just a normal relationship" with clients for a long time without burning herself out. In their anecdotes, Aubrey and Lena identify their struggles to find balance and harmony within nurse-client relationships that benefit the care of the client and preserve the longevity of their nursing careers.

Isabella and Robert had consciously set the clearest boundaries for the nurse-client relationship of all the participants, citing therapeutic relationship as separate from a personal relationship. They claimed their relationships with clients were focused on the care of the client. They claimed that anything they told the client about themselves was carefully considered within the guise of appropriate self-disclosure for the benefit of the client. For instance, Robert claimed that:

> Uh…so, with Aboriginal patients that I have dealt with, I can bring my own life experiences and my own history to theirs. [But] I am not going to sit and share my own life story with them, obviously…that's not a therapeutic way of...not a therapeutic relationship. I mean, a little bit of self-disclosure can help form a bond with them and stuff like that…but they don't need to know my entire life history. (Robert)

While Robert's personal history was a means of better understanding some of his Aboriginal clients, he was clear that any bonding with clients was for the purpose of the client's treatment or recovery. In the same way, Isabella claimed that:

> Yah, I understand patient boundaries; you are not going to talk to them about their personal life, although sometimes it is appropriate to do so. The patients are always asking if I have babies. No, I don't have babies, not yet. I am getting married. Things like that are okay. It's still within the nurse-patient therapeutic relationship. (Isabella)

Isabella would only speak to a client about his or her personal life if doing so would benefit the care of that client. When asked personal questions by her clients, in this case expectant mothers who asked her if she had children, Isabella told me she was clear about which responses built a therapeutic helping relationship between nurse and client and which responses she felt were inappropriate in her professional role.

These six participants sought nurse-client boundaries based on their perceptions how close or how far nurse-client relationships ought to be in their NPRs . Two participants (Danielle and Kathryn) sought closeness with their clients, two participants (Aubrey and Lena) sought distance from their clients, and two participants (Robert and Isabelle) set clear boundaries with their clients based on their interpretations of therapeutic relationships.

Classmates: Soldiers in White

Nursing students are easily identifiable within hospitals and facilities because they wear white scrubs with a black university crest on the shoulder of this uniform. Once they graduate and accept their first professional nursing roles, nurses may generally choose the colour, pattern, or style of their scrubs to communicate to others their uniqueness as individual nurses. In this study, I had not asked any questions related to communication and relationships with or between nursing students classmates. However, five participants (An, Aubrey, Danielle, Robert, Wren) reported that their friendships with other nursing students positively impacted on their ability to

ride the ups and downs of NPRs because "everyone is going through the same thing" (Danielle; Wren). The participants told me that their classmates had helped them soldier through the range of positive and negative experiences of interpersonal communication and relationships with clients and nurses of NPRs. As Wren, a participant who had often relied on her classmates' encouragement explained:

> We went through so much together in that semester that the only thing that kept us sane was having each other, and being able to…you know when a CEF told one of the students, "Stop crying now. You need to pull it together and be a soldier", she [the student] could talk that [experience] over with us after. Go through that process with us. So I would say, make those connections with the other students because they are going through the same thing at the same time. They are the most useful resource that you have. And you are all learning to take on the role at the same time. You go through that transition together. (Wren)

When Wren's classmate had been reprimanded by their CEF and told to "be a soldier", it was her classmates who helped her to make sense of this feedback. The nursing students had empathy for each other's experiences because they were at the same moment in their socialization to nursing. Similarly, Aubrey's classmates helped her to maintain perspective when she had had negative experiences of communication with nurses and clients:

> ...there were a lot of great experiences, but I also found that there were a lot of days that I felt [like] I don't want to be a nurse anymore. You use the support of the people around you to kinda..pep-talk you back up, but it helped knowing there were other students around feeling the same way at times. I mean, you don't want to all feel down in the dumps together, but it made me feel like you weren't alone. (Aubrey)

The "pep-talks" from fellow students helped Aubrey continue with NPRs when she felt discouraged and was not certain she could find her place in nursing. Aubrey felt comforted when other classmates communicated similar feelings and experiences. Thus, Danielle's advice to future nursing students was to:

> Really form a relationship with the people that you are going to be working with, especially the students because those are the people who are going to be helping you out. Everyone is going through the same thing…I felt like the students were the biggest

> component of nursing for me because I always had someone to go to if I needed a question, or advice or what to do. They can be for everyone else, I found. (Danielle)

Therefore, participants who formed a supportive and encouraging community with classmates received support, encouragement, advice, and empathy that they may or may not have received from the nurse educators and nurses on their NPRs. Relationships with the other classmates or soldiers in white enabled participants to communicate their challenging experiences on NPRs with others who understood what they were experiencing.

Buddy Nurses: Perceptions of the Buddy System

In health care facilities, each student's assigned client has a staff nurse or Registered Nurse, whom the students call a Buddy Nurse (BN). The Buddy Nurse coaches the student to care for his/her client to the extent that the student is knowledgeable and skilled to provide safe competent care.

Within this study, five participants (June, Aubrey, Lena, Danielle, An) commented that they had limited opportunity for relationship with Buddy Nurses during their initial year of NPRs (the second year of nursing education) because they perceived that they were dependent on CEFs to guide them through client care. At this point in their nursing education, the participants argued that they had limited nursing skills and knowledge, or in June's words, "We were such new nurses. We don't know much" (June). At this stage, the Buddy Nurses "expected you and your CEF to report if something is off" (Aubrey); otherwise, "They weren't really around to be involved with us" (June). As a result, they felt that their first experiences with the Buddy Nurses were filtered through the CEF.

Moreover, nursing students in the first rotations have one to two clients in their care to allow the time for them to learn. As Danielle, a nursing student who was well-prepared for her first year gerontology rotation, explained:

> I feel like initially, in second year, you didn't really have any rapport with the Buddy Nurse because the CEF was around us. You had one or two patients, so you don't really need to ask. The patients have been on these medications for a very long time, and you understand them [the meds] because you have done all these drug cards. I feel like personal care homes are different and labour and delivery too because we didn't have the skills and stuff. We didn't really need the [Buddy] nurse...I don't feel like we did have a strong rapport with Buddy Nurses because the CEFs were always there to fall back on. (Danielle)

In other words, the participants at this stage of their nursing education perceived that they were exposed to fewer more routine client cases through the guidance of their CEFs. Within structured or controlled learning on her first NPRs, Lena who was a high achieving student in the classroom claimed that she had sought contact with her CEF to prove to the CEF that she was improving and learning:

> when you are a student, it's the CEF is the one who is evaluating you, and you go to them and show them what you are doing so you can be evaluated. Their opinion is given more weight because they are the one who decides if you pass or get the grade or not. In that way, I don't remember having many Buddy Nurses who really had an impact on me. Probably because I was so focused on making sure that my CEFs liked what I was doing, right? (Lena)

In this way, Lena was focusing on traditional measures of student achievement at the university, the letter grade. If the Buddy Nurse was not part of this evaluation process, Lena saw this nurse as less important than the CEF (who assigned the grade).

Therefore, within the first NPRs, the participants perceived that their interactions with Buddy Nurses were limited due to their novice status within the rotation and their expectations for traditional teacher-student (CEF-nursing student) relationships. In this way, they perceived that the BN was a relationship they, as nursing students, needed to work towards.

Course Leaders: There but not There

Course Leaders (CL)s oversee all NPR groups in an area of nursing practice, so they travel to numerous health care facilities to monitor and check on the clinical groups. In the

nursing education program in this study, a CL, has an average of 10 groups of one CEF and six nursing students to supervise at numerous locations of NPRs in the city where a given area of nursing practice (medicine, surgery, palliative care, mental health, etc) occurs in the care of clients. Therefore, the average CL in this study oversees 10 CEFs and 60 students in their interpersonal communication and relationships as nursing students learn to become nurses.

When asked about their relationship with CL or experiences communicating with CL, half of the participants (Lena, Kathryn, Danielle, Sophie, June, Aubrey) explained that if a nursing student was passing (not a risk to client safety nor posing any disciplinary concerns, for example) within the NPR, this student had little to no contact with the CL. For instance, June found that "There was never too much involvement" (June) with her CL and Aubrey stated that "I had minimal contact with [CL]…I seriously felt that they didn't impact my experience at all. They maybe signed my evaluation form but I never talked to them" (Aubrey). Danielle, a similarly strong student on NPRs, "I felt like they weren't really there. I am trying to think of who they even were...I think I met the CL once, maybe the first or second day, and that's it. Because I never had any problems, I guess that's why I never saw them" (Danielle). Therefore, in June, Aubrey, and Danielle's experiences on NPRs, CL existed, yet they did not have communication nor a relationship with their CL because they were progressing well on their NPRs.

Other participants were more critical of the CL because they had been unable to establish communication, rapport, nor relationship with these nurse educators. Kathryn stated that, I found with the CL, unless there was a problem, they wouldn't talk to you" (Kathryn) and her tone implied that she felt ignored by CL. Sophie "never found [CLs] helpful. I never quite knew what their role was, and where I was able to talk to them. It didn't feel like open communication"

(Sophie). Sophie, a nursing student who saw nurses as compassionate healers, was confused by the role of the CL. If the CL was to support her learning as a nursing student and the CEF as an educator, why did the CL not engage in communication and relationship with her and her classmates?

Participants like Lena who did have contact with the CL in one of her final rotations, commented that "I really saw her step in as the Course Leader and it really highlighted for me that Course Leaders are overseers. If you are doing well, and you are just kinda going along and you are not having any challenges, you are not going to see the Course Leader. But if you are having challenges, then they do step in" (Lena). Lena's experience in this instance was to be asked to meet with the CL because Lena, who had fast-tracked her nursing education, had written a reflective journal with "lots of words in which I am frustrated, tired, really lots of red flag types of words...I didn't see the point of this last rotation…I really just felt like it was a waste of my time." (Lena). Lena explained that this CL had met with Lena and expressed an interest in Lena's challenges, and the CL told Lena she wanted to address these problems for future nursing students on the same NPR which Lena appeared to appreciate. However, Lena also told me that the CL had scolded her for not coming forward sooner, so the CL could address problems sooner to improve Lena's experience of the NPR (rather than afterwards on a course evaluation). Lena had sighed and paused at this comment. Nonetheless, June, Danielle, Sophie, and Kathryn, Lena experienced the CL as an administrative role rather than an educator role.

Three participants claimed that the exception to the above statements was the Course Leader who also taught the accompanying theoretical course at the faculty (Isabella, June, and Jillian). This link between the Course Leader at the NPR site and the theory course on campus, opened up possibilities for trusting communication because if "you were in their class then they

would ask you questions about clinical" to bridge theory and practice (June). Isabella who often sought out mentors among faculty members claimed that "The Course Leaders were a resource to the students, especially if the Course Leader also taught theory classes on campus" (Isabella). Jillian, who had experienced a miscommunication with her CEF, went to speak to her CL about it because this CL had also been her Instructor in one of her theory courses on campus:

> If you had a problem with your CEF that you couldn't resolve, then you went to the Course Leader. That's how the lines of communication were generally laid out… I had once case where I had a little misunderstanding with my CEF and I did go talk to my Course Leader about it. I found that very helpful because it was a little more of an objective view. I mean, this Course Leader had also been my Instructor, so we already knew each other which made it easier. It would have been really hard otherwise to go to the Course Leader if I hadn't known her before. (Jillian)

Therefore, these participants perceived that the intimidation of being evaluated was reduced by a prior relationship with a CL whom they had known as a theory instructor in the classroom.

More generally however within this study, the participants perceived that the CL was only present or stepped in when a student was struggling within the NPR. Nearly half the participants claimed that their communication and relationships with CL were minimal because they had progressed well on the NPRs. In this regard, the participants experienced the CL as an administrative role within the NPR.

Preceptors: Mentors

At the site, each SP nursing student works with a *Preceptor* (P) who is an experienced staff nurse in this area of nursing practice and who gradually mentors the student to reach a full client load (also known as *patient load*) and meet entry level competencies. In other words, the relationship at the beginning of the rotation is one of a teacher and student. By the end of this final NPR, the nursing student has completed nursing education and is essentially a colleague

with the Preceptor. In this study, only four participants cited examples of this mentor and mentee relationships and communication with the Preceptor or faculty advisor.

Jillian and Isabella's comments below illustrate their growing independence and capabilities on their final NPR. By the end of the rotation, they reached a full client load and took over the work of the Preceptor on the unit. For Jillian on her Senior Practicum placement, her Preceptor "would watch me do everything, and then she would be like "You are good at that. You can do that one on your own from now on" and you then knew that you were fine" (Jillian). Therefore, Jillian gained confidence as the Preceptor confirmed that she was ready to practice as a graduate nurse. Isabella had completed her Senior Practicum. Over time, Isabella assumed the role of her Preceptor:

> They liked having nursing students because by half way through, your [Preceptor] just sits at the desk. Except for [acute care], you should be pretty much on your own and it's one to one nursing, so you are that nurse. So therefore, they don't have to really do anything! So they like nursing students. It's a lot of work at first…The first half is really heavy because you have to teach people, but the second half…I think my Preceptor sat at the desk for most of the shifts. (Isabella)

Isabella saw the advantage of being a Preceptor to nursing students; the Preceptor trained, guided, and coached Isabella in the early stages of her Senior Practicum, and by the latter half of this NPR, Isabella could manage the majority of the Preceptor's work. The Preceptors supervised with the exception of deliveries, and they enjoyed the benefits of role, such as caring for the "cute patients" (babies).

Therefore, the few participants who commented on their Ps saw the P role as a support that gradually faded out as they grew increasingly independent over the course of the Senior Practicum. As the communication and relationship shifted from that of a mentor-mentee partnership to that of colleagues, the Preceptor enjoyed a reduced workload.

Nurses in Unit Cultures: Picking up the Vibe

The participants struggled to define or articulate a 'culture of nurses' as a whole. Rather, nine participants (June, Lena, Meredith, Jillian, Aubrey, Isabella, Wren, Kathryn, and Robert) claimed that each nursing unit is a unique contextual environment or culture. Moreover, they saw a *unit culture,* which June referred to as a "vibe" (June) and Lena called "the ceiling" (Lena), as directly or indirectly created by the interpersonal communication and relationships of the nurses on that unit. Meredith, who had taken note of the words, attitudes, and behaviours of the nurses on the units of her NPRs, claimed that:

> The number one biggest factor is the culture of the unit. Nursing is nursing, the skills are the skills…it's where you are nursing and every unit has its own distinct culture. And if you enter the culture of the unit where they just support each other, that's just what we do, we don't tolerate anything less. You get used to that attitude and everyone adopts that attitude. A lot of the time, I saw that it [the attitude/the culture] usually comes from the top, the Charge Nurse and the Manager don't tolerate anything less than that. That is the culture of that unit. (Meredith)

Meredith described the unit culture as the institutionalized attitudes and behaviours of the nurses on the unit that are expressed through communication and relationship. As such, she saw the unit manager or administration's communication and relationship with the unit nurses as setting the tone for the way in which the unit nurses relate to each other, and in turn, nursing students on that unit.

The participants identified that unit culture of the nurses influenced them because, as nursing students, they had to learn to identify and interpret the context through nurses' words, body language, tone of voice, attitudes and relationships in order to adapt to the unit culture and establish communication, rapport, and relationships with nurses on that NPR. June explained her adaptation to the unit culture as, "You have to pick up on the vibe of the situation...I think it's all about picking up that vibe and feeling it out and seeing how it's going to be" (June). To fit in on

the unit, June had to observe the nurses' interpersonal communication and relationships to determine "how it's going to be", in other words, how the nurses address and relate toward each other on the unit. Of the nine participants who were aware of variations of the unit culture across NPRs, six participants were able to articulate the "vibe" as a negative or positive unit culture, including its impact on them as nursing students.

The six participants consistently described positive unit culture as an environment where nurses communicated in ways that were: knowledgeable (Lena, Robert), supportive and compassionate (Meredith), positive, caring (Sophie), solution focused (Isabella), and as an advocate (Kathryn). To illustrate, Lena thrived in positive unit culture because the nurses had been supportive of one another in their practice of palliative care nursing on the same unit for several years:

> It's the nurses on the unit that create the vibe and create the ceiling, and really were able to provide the support to do that kind of nursing in that area. What I really loved about the palliative rotation was that the nurses at X have been there for such a long time, and they have so much experience. The CEF had also been there for a very long time. The nurses who do it every day, they really have this wealth of knowledge that I just want to soak up. It was just really neat to see them at their work. (Lena)

In this instance, the CEF was able to integrate Lena into the culture of unit because this CEF also worked on the unit. Despite being a cohesive team of nurses over an extended period of time, Lena felt welcomed into this unit culture by nurses who communicated in ways that engaged her in their practice. Lena felt that these nurses wanted to share their knowledge with her.

Similarly, Meredith saw positive unit culture as created by nurses who were compassionate with each other:

> I think it was mostly the nurses that were on the unit too. I'd never seen nurses work like that before. If someone made a mistake on the previous shift, they'd say "Good thing that you caught that let's fix it now." Instead, I'm used to the response of "Oh, that nurse is so lazy. She doesn't know what's she's doing", you know those kinds of responses? Instead

> being super supportive, “Oh, she worked nights and it’s really hard being on nights”, so absolute 100% support. I had never seen that on a unit before, and I thought “That’s the kind of nurse that I want to be”, instead of putting someone down or the way that they talk about patients like “Oh, that patient’s family is so demanding”, they went out of their way for those extra demanding families and said “Well, they are just having a really hard time with it right now”, or just the way that they reported off about it. It was just so different. Instead of like “Oh, that patient is so aggressive”, they said “Oh, this patient is just having a hard time with this. How can we problem solve around it?” That’s why it was such a great experience for me. (Meredith)

The nurses understood the challenge of “being on nights” and this kindness was extended to the clients who might have seemed “demanding” or “aggressive” to Meredith. This positive unit culture was a memorable experience for Meredith because the nurses had exposed her an alternative way of relating with nurses and clients. Meredith admired these positive nurses and aspired to find a nursing job with the nurses who had a positive unit culture.

Thus, the participants had experienced positive unit cultures as created by nurses who are supportive and compassionate in their care of each other, the clients, and nursing students. Participants who provided examples of positive unit culture perceived that they had thrived within these positive contexts because they had learned from the nurses and felt safe with these nurses.

In contrast, five participants described negative unit culture as an environment in which nurses’ interpersonal communication fostered disloyal and distrustful interpersonal relationships between nurses (Meredith, Aubrey, Kathryn), complaining (Wren, Meredith), the perception of a lack of time (Aubrey, Robert), disinterest in clients (Meredith), and an intolerance of nursing students (Aubrey, Isabella). Nurses’ interpersonal communication on such units was abrupt, aggressive, confronting, and tense. Aubrey experienced this “tension” among nurses on one NPR as, “I remember conflict on one unit more than usual..There was a lot of conflict between the

nurses for sure. You could just feel the tension" (Aubrey). Meredith described a negative unit culture in which the nurses were confrontational with their superiors, colleagues, and clients:

> …The culture of that unit was if you don't like someone, tell them to their face and you don't need to be nice about it. The manager was even like that, but it didn't function well and felt awkward a lot of time to be around it..And they were like that with the patients too. Instead of figuring out "why is my patient really angry all the time?" instead of taking the time to delve a little deeper, they were just like "Uh…that patient is so demanding. They are always on their call light." More just, complaining about it instead of figuring out the reason. You think, well…I can see how you would get into that if you work on that kind of unit…But you can so easily fall into the those habits of just…getting into conflict with everyone and it becomes overwhelming, and it's a cycle, you know. (Meredith)

In this unit culture, Meredith claimed that the nurses had lacked diplomacy, interest in clients, and job satisfaction. Again, the unit manager or administration set the tone for such interactions by telling "them to their face and you don't need to be nice about it." Meredith identified that this negative unit culture was contagious and self-reproducing. She had insightfully recognized that a nurse who worked on this unit would likely adopt this negative communication over time.

Wren, Aubrey, and Isabella perceived that the unit culture impacts nurses' willingness to engage in interpersonal communication and relationship with nursing students. Sometimes, Aubrey stated, the CEF was being kind if she did not assign Aubrey to particularly negative nurses within a negative unit culture; Aubrey was relieved for "It was hard being a student because if you don't want me, I don't want you" (Aubrey). Isabella also claimed that some units did not like having nursing students, "They found us to be a hindrance. They were not as helpful. The unit clerk rolled her eyes when someone asked her a question. They just didn't want nursing students there so they didn't make it a positive experience, I guess they hoped that they would stop getting nursing students" (Isabella). Wren who needed support to communicate with nurses and clients alike on her NPRs found that:

> ...you get some nurses who are so experienced that are so generously willing to teach, and then it's a whole different story. And it's very much about the culture of the unit too. I think that whole 'eat their young' thing is the culture of the unit. From unit to unit and from individual to individual...I think there is more bitter unit culture or a culture of complaining. It becomes very negative very quickly, and even if it's as a way of bonding. It can be very negative. There can be a lot of behind the back complaining about everyone else. Like people are bonding with the other nurses by complaining…you complain about this nurse with your friends, and then it turns right around because that's the culture. In that way, people are less polite and collaborative in communication as soon as some of that starts.... (Wren)

Wren understood that it was inappropriate for her (and the other nursing students) to complain to the nurses about clients or nurses like the other nurses on the unit; Wren claimed that the nursing students were outsiders. To Wren, being a nursing student meant learning to find one's place within an established hierarchy, and the consequences for dissention from one's place on the hierarchy was that the unit nurses would "eat their young." These unequal relationships were reinforced through communication channels that included staff nurses and excluded nursing students. As Wren explained, "If the bonding is happening through complaining, you can't participate in the negativity as a student nurse (not that you should). So it kinda blocks you off from having those connections with people; it places you in even more of an outsider role. When you are at the bottom, you can't complain" (Wren). Within these negative unit cultures, Wren, Aubrey, and Isabella felt they were blocked from communicating with nurses and participating within the unit in their capacity as nursing students,

Within negative unit cultures, some participants reported feeling afraid (An), intimidated (Wren, Robert), awkward (Aubrey), and inferior (Meredith). For example, Meredith had experienced negative unit cultures where new nurses were unsupported and intimidated:

> There were some units where that old adage of 'Nurses eat their own young' became very apparent. Where…there would be a new nurse and they would be like "That new nurse doesn't know what she is doing", or you know, there was just that lack of support. You'd feel inferior to the nurses who had been there for a really long time. You were afraid to

> ask them questions because they were really short with you. They were like that with the patients too. It just made it really hard to communicate with them. When you felt like you couldn't ask them anything… You know, I think maybe they are jaded…but that's what comes across when they are talking to you. There were a few units like that. (Meredith)

Communicating and forging relationships with nurses who gave Meredith the impression of being "jaded", tired and disinterested in nursing practice, was challenging for Meredith who could see the larger perspective of a future in nursing.

Three participants (Meredith, Kathryn, Robert) recalled that a negative unit culture had negatively impacted relationships between nurse colleagues, and they shared how they had actively attempted to distance themselves from the negative interpersonal nurse to nurse communication on the unit. Meredith looked forward to the future when she could select her workplace, "As a student, I thought, this is fine because I'm not involved in that but I would never want to work on that unit. That's not the way that I communicate with people. I think there's a way of dealing with conflict without being so aggressive about it" (Meredith). Kathryn refused to participate in gossip with the nurses, but rather went outside to the park on her breaks. Kathryn told me, "I think sometimes people [nurses] manipulate the situation to make themselves feel better and to make the other person feel better. But really! It is such a stupid situation! It's ridiculous...but everyone is taking these things so personally" (Kathryn). Kathryn wanted to distance herself from what she saw as unnecessary drama among the nurses within this negative unit culture. Robert learned to read the moods of the nurses and choose whom to ask for help:

> She is really really busy and I don't want to bug her [the nurse]. If they were having 'one of those days', they could really take your head off if you did stop them with a stupid question. It didn't happen often...but you did get to realize 'maybe she's having a bad day?', so maybe I'll ask this nurse over here [instead]. She's in a better mood. (Robert)

Overall, the participants' statements indicate that they did not learn well on such units where avoiding the difficult personalities appeared to be the only option. Within negative unit cultures, the participants perceived that they were, as Wren stated "just trying to make it through and glean a bit of approval if you can" (Wren). Within such contexts, the participants were fearful learners.

Younger and Older Nurses: Generational Considerations

Ten of twelve participants recognized generational differences among nurses, yet these participants saw generational differences as presenting both opportunities and challenges in communication and relationships on their NPRs. Like many of the participants, Jillian remarked, "I could never really decide if I liked working with the quite new nurses or the older nurses" (Jillian). In other words, the participants consistently stated that both younger nurses' and older nurses' taught them valuable lessons in nursing through interpersonal communication and relationship.

When the participants discussed generational differences among nurses, they spoke of younger nurses in contrast to older nurses without giving specific age demographics or years of experience. The implication was that the younger nurses were from the participants' own generation and older nurses "had been there a long time" (Robert). For example, June explained that she "had three Preceptors, two were young with kids and one was middle aged and a few years from retiring maybe. You could definitely tell the difference between all of them. They are all very good.... I dunno. You could tell there were differences but they weren't bad differences" (June). Thus, this perception of the participants' generation being/existing in contrast to the experienced or older nurses was based on comparison of the self to the other (not like self) in a dichotomy of younger versus older nurses. Nonetheless, the participants had consciously

adjusted their approach to communication and relationship depending on the generation of the nurse with whom they were interacting.

Four participants (June, Wren, Jillian, Lena) claimed that younger nurses, some of whom were graduate nurses in their first years as professional nurses, were easier to approach with questions and concerns, and easier to relate to than older nurses. June, a friendly caring young woman from a close-knit rural community, perceived to have had more in common with the younger nurses who were closer to her in age, "With the younger ones, we talk about school or new grad stuff or that sort of thing" (June). In contrast, Wren, an introverted and cerebral young woman, identified that the communication and relationships between the younger staff nurse and nursing students did not replicate the power dynamic between older established nurses and nursing students. As a nursing student, Wren had felt submissive to more experienced older nurses. With younger nurses, Wren felt she could often communicate within a relatively equal peer relationship:

> When you have a younger nurse who is new, a lot of that [having to be submissive] is lessened and [you] cooperate on a more peer level which in general is better for learning. I feel more comfortable asking questions, approaching them with anything. There's not that gap, especially if they were new grads, it was much easier to feel comfortable talking to them. That's obviously not true across the board; there are some exceptions. (Wren)

To Wren, this gap in power and experience between Wren and the older nurses had caused her significant anxiety on the NPRs of her nursing education, and the gap had been reduced for Wren in interpersonal communication and relationships with younger nurses. In fact, Lena who prioritized community building among nursing students, felt that the younger nurses were changing the 'nurses eat their young' approach to interpersonal relationships between more experienced nurses and younger nurses:

> I think, it's really changing, this idea that 'Nurses eat their young'. The hostile environment is changing but it only changes if students are encouraged to ask questions

> and expect that that environment has changed....and are able to point out when it's not, that's when things change... I think it is coming from the younger nurses... There is also young nurses not taking it. Not expecting that that's okay anymore and speaking out for themselves or for each other. I think in the past, there was a just a culture of "you just have to serve your time in the trenches", you have to....the rite of passage to be chewed out by somebody. I just think that's no longer the case. It's just not. There are enough rites of passage for nurses. That doesn't have to be one. (Lena)

Lena asserted that younger nurses were changing the unit culture of nurses by standing up to the more experienced nurses who had participated in creating negative unit cultures through interpersonal communication that included "chewing out" (meaning to belittle, reprimand, scold, yell at, or tell off) younger nurses and relationships which implied that younger nurses were "serving your time in the trenches" (treated poorly as older nurses had been treated poorly when they were young nurses). According to Lena this "rite of passage" for younger nurses could only end with younger nurses' choice to stop the cycle with their own nursing students.

At the same time, Jillian, who had discovered over time that some nurses helped nursing students learn, while others saw them as an ignorant and time consuming nuisance, identified that some younger nurses "were great because they remembered very well how it felt to be a student...Or you could have the really new grad nurses who didn't want to help you either....they were feeling overwhelmed and the last thing they felt like doing was guiding us students. They were hardly comfortable with it themselves" (Jillian). Stated another way, Jillian identified that nursing students and new graduate nurses in their first years of practice often share some of the same priorities and experiences in that they are both still learning. However, Jillian also saw that some graduate nurses were trying to survive in their first nursing roles and did not want to guide nursing students. Therefore, a friendly peer relationship between herself and the younger nurses was not always assumed.

Generally, the participants in this study were able to initiate relationships with younger nurses than with older more experienced nurses because that both nursing students and graduate nurses were still learning. Moreover, some participants perceived that the younger nurses fostered a more equal status among young nurses and nursing students while others observed that graduate nurses were simply trying to survive their new roles as professional nurses and did not take the time to engage with nursing students.

In contrast, eight participants (June, Danielle, Aubrey, Lena, Jillian, Robert, Wren, Isabella) perceived that the older nurses whom several referred to as "Old School" nurses, were more experienced, knowledgeable, as well as able to better anticipate a client's needs and manage the clients' emotions as well as their own emotions within the contexts of care compared to younger nurses. June, Danielle, Aubrey, and Lena told me that they valued their relationships with these experienced nurses, particularly when these nurses modeled interpersonal communication with clients who had complex needs. For example, Aubrey who felt that she depended on nurses to guide her practice stated that "the longer the nurse had been working, the better they were with dealing with feelings and situations. They were the great ones to watch in situations like that…for different patient situations, they were very adaptable, they communicated in all sorts of situations. They knew what to expect" (Aubrey). While Lena claimed that she did not always agreed with a more experienced nurse's communication style or approach to relationship with the other nurses and clients, she valued that some of these experienced "characters" got the job done:

> I think it's also learning the differences of characters. I have met some older nurses who are just characters all to themselves...people who, if I was on their bad side, definitely wouldn't want to be there, right? Who can come off as really really strong. But if you're in a pickle, and you are with a difficult patient or if you are with someone who has lots of behavioural issues, you want them on your side, right? Because that's not the moment to be kind and caring. That's the moment to be decisive, clear, and stern. And...it's...the

> more you work, the more you realize that it's such a team effort and you really need them there. And sometimes you are like "Maybe that's not how I would do it, but...it works for them. (Lena)

When Lena was "in a pickle" (experiencing a challenging client), this older nurse's decisive, clear, and stern approach to relating with the client was useful. Lena just wanted to avoid being on the receiving end of this older nurse's communication.

Danielle, June, and Jillian appreciated older nurses' knowledge and experience to the extent that praise or guidance from these older nurses gave them confidence in their practice. To illustrate, Jillian explained that:

> The older nurses were more experienced. They knew a lot more. Some of them used that lot more knowledge to be super confident and be so confident to lead us through everything, right? They would do something with us and make us feel really confident, like "Yup. You are doing great! That's wonderful", and they would make us have a really fabulous experience doing something that you were a little bit unsure about when you started. (Jillian)

In this way, Jillian gained confidence from the older nurses in a way that she could not from less experienced younger nurses because the older nurses' guidance and praise was perceived as more reliable and credible. However, Jillian also noted that "then you could have the flip side of that; you could have an experienced nurse who was so experienced that she could not at all remember what it felt like to be a student" (Jillian). Stated another way, Jillian had also encountered experienced older nurses who had difficulty relating to nursing students. These nurses struggled to communicate their wealth of knowledge in ways that were meaningful to nursing students like Jillian.

In fact, four participants (Robert, June, Wren, Isabella) had experienced difficulty communicating and building relationships with some of the older nurses whom they experienced

as stern, intimidating, controlling, and set in their ways or routines. For example, Wren claimed that:

> The more experienced, the further the gap and the harder it was to approach them. The more careful you have to be in approaching, not to be…to be respectful of your place on the bottom most rung. To handle things more delicately. Less in your face than younger nurses. I guess just being more respectful in your communication. Plus with the generation gap, there can be quite a big age gap. (Wren)

In other words, Wren found that with increasing age and experience (the wider the gap) of the older nurses, she had to show increasing deference to the older nurse. Being one of the least experienced nurses unit, Wren felt she had to show humility and respect for the older nurses. As a result, Robert, a mature student with a 'go with the flow' attitude, experienced some older nurses as rigid:

> The older nurses especially, they have got their routine down and heaven help you if you interrupt them. Sorry! The younger ones [nurses] who have just graduated were much nicer [laughing] because they were where you were not that long ago. The ones who have been there [on the unit] for 25 years, maybe they don't remember how scary it was. (Robert)

Robert found that some of the older nurses could not relate to nursing students' status as a novice nurse. Similarly, June was intimidated by an older nurse whom she saw as dominating and set in her ways:

> There is an older nurse...I am so intimidated by her!...I've had the feeling like I am not really sure what to do or where to step in because she's kind of doing it all. Her way or no way, that's kind of how she is in particular... She'll always have something to say. She always has her own opinion. It could be her as a person or her generation, but she has been there for a long long time. Yah. But other people realize that she's like that too. It's her way. She does her own thing. I think even with the doctors, she kinda takes over. There has been times when she has taken over and the doctors kind of stepped back [laughing]. (June)

June's feelings were eased somewhat when she discovered that other individuals on the unit also shared her experiences of interpersonal communication and relationship with this older nurse. To

June, this nurse communicated an attitude of superiority and control over client care. Isabella had also experienced "old school" nurses who exercised this form of control within teaching and learning encounters on NPRs:

> I ended up with a lot of old school nurses who like wanted things done their way, or for me, not to do it at all. There was only one…when I get overwhelmed, I'm like a crier. I don't like it, but when I get really overwhelmed, I cry. And I only cried once at clinical practice which I thought was pretty good for three years. It was a really old school nurse…it was valid what she was doing, it's just that if someone stands over my shoulder when I am trying to do a nursing skill, I just don't do very well…. know how to do it; I just don't think you need to be over my shoulder watching me do it. But I understand that they want their patients safe, and they are worried. That's fair. She just totally had me freaked out, and I just kept fumbling things. She pretty much insinuated that I was going to kill someone. She was confused when I started to cry? I mean, I know you are trying to do the best for the patient, but the way that you are doing it is not positive, private, or personal. It feels like an attack in front of a patient. This is the patient that I have been caring for all day, and the family enjoys having me as a nurse. Now you have completely just ruined all of my credibility with this family! (Isabella)

Isabella had understood that she was to perform care as these older more experienced nurses did, or, if she was not capable of providing client care in their way or to their standards, Isabella understood that she should get out of the way.

Hence, participants' relationships with experienced or "Old School" nurses were perceived in two main ways. They perceived these nurses to be more experienced and knowledgeable nurses who modeled complex interpersonal communication and build confidence in some participants, yet they experienced some Old School nurses as intimidating, dominating, inflexible, and impatient in their communication with nursing students.

Statuses

The participants experienced their status as nursing students relative to their CEFs, Buddy Nurses, Course Leaders, and within the context of unit of the health care facility or institution. Their perceptions of their status(es) is elaborated upon within this section. Moreover,

the ways in which the participants' viewed their treatment by other nurses and any attempts at resistance of their status as a nursing student are described below.

Status Relative to CEFs

Half of the participants shared their experiences of their status relative to the CEF (Meredith, Aubrey, Robert, Lena, Isabella, June, and Kathryn). While the previous section on CEFs described their experiences of grades and CEFs, this section outlines the participants' experiences of status on NPRs and feelings of lacking power relative to the CEF.

Several participants perceived that their communication with their CEFs was hindered by their fear that the CEF would enforce retribution (in the form of failure, a lower mark, humiliation) for disagreeing with the CEF. For example, Meredith who maintained her conviction to avoid spending money on her client during one of her first NPRs was singled out and belittled by her CEF in front of her classmates:

> I am not used to being in conflict with anyone. And she [the CEF] and I were just not seeing eye-to-eye on how the clinical rotation was supposed to be. I felt like she would make suggestions on things that I should do; I wasn't completely comfortable with that. It was a community geriatric rotation and we were supposed to leave them [the clients] with something final to do. And a lot of people [nursing students] were spending money to get people [clients] things in their home, and I just didn't feel comfortable spending money. As a student, I didn't have much money, and my CEF kept saying that I had to come up with something that was more than what I was doing. And I said "I just don't feel comfortable" and she said that "I should buy him a model airplane because he likes model airplanes, even from the dollar store" and I said that I don't feel comfortable with that because I am not going to start buying things on every clinical rotation and spending money just so I can get a better grade…is what it felt like. So that I can show that I can put in the effort. I did something that didn't cost money, and she [the CEF] didn't think it was very good at all…and there was a particular moment where we [the nursing students and the CEF] were all sitting around, and she really singled me out, and the other people in the group agreed that she was quite rude, and it was really…the only experience I had with a CEF where I thought "I hope it's not going to be all like this. (Meredith)

Therefore, Meredith perceived that she had experienced punishment for speaking and acting against her CEF's suggestions of a gift for her client. Meredith had voiced her concern and attempted to negotiate with the CEF privately during the course of the rotation; however, Meredith felt that the CEF used her power as the educator to intimidate Meredith and her classmates. The message that Meredith had received was that nursing students must listen to the CEF or suffer a consequence.

Robert had also experienced being intimidated by a CEF and he identified a pattern of behavior in one CEF:

> I had the CEF who was on me like white on rice. It was pretty brutal…Some of it though was that she would ask me a question, and I would get confused by something else and give the wrong answer. But she would never take my correction. So, she would be like "No, you gave me the wrong answer. (Robert)

Robert explained that he overcame the stressors that were holding him back from quickly producing the right answers by accessing support systems outside the nursing program. However once he could produce the correct answers, Robert reported that his CEF moved on to another nursing student on the same rotation:

> [S]he was literally on to another nursing student; it was brutal to watch! This poor nursing student, she always spent at least some time of the shifts crying. They say that 'nurses eat their young' and they are not kidding! Like, that was just brutal to watch. …with that situation, the CEF was really down on the nursing student because she did not think she was prepared enough. It was hard to watch. Like, it seemed like no matter what the nursing student did, there was something wrong. (Robert)

Robert was a mature student who did not appear to personalize this communication and behaviour from the CEF, but rather sought out supports to improve his performance and satisfy his CEF. He had noticed that, when the CEF replicated this behavior and communication with the next student, Robert worried that this individual did not have the emotional resources to cope.

Similarly, Isabella, a nursing student who tried to help other nursing students, claimed that the CEF could decide what kind of communication on the rotation was acceptable:

> I think where students get lost is when they feel like their own nursing practice can't fit in the model that their own CEF is trying to uphold. Like I have seen really good nursing students fail because they couldn't communicate properly with their CEF. Especially one student that I recall; she was just so gentle and shy, and her CEF was like so blunt and harsh and straight to the point. So the tactics that she used like pop-quizzes and rapid fire questions didn't work well with this student at all. So this student couldn't figure out the way to get help fast enough, and by the end, she ended up failing that clinical rotation. She was held a complete year back, and the only real reason was because her communication style didn't match her CEFs' style. (Isabella)

In this way, Isabelle felt that the CEF exercised her status as the educator over this nursing student by setting a moratorium on any other style of communication except her own, a direct style that Isabella perceived as blunt, harsh, and straight to the point.

Thus, several participants experienced that interpersonal communication and their relationships with CEFs were shaped by the status of the CEF. The participants shared stories of interactions with their CEF wherein they perceived that CEF retaliated against students who were not communicating in ways that the CEF felt were acceptable or appropriate (refusing to give a gift to a client, being shy or gentle, taking time to provide answers to the CEF's questions) for a nursing student.

Status Relative to Buddy Nurses

The participants had contact with Buddy Nurses in their third and fourth years of NPRs. In these NPRs (surgery and restoration), nursing students have greater responsibility within more complex care than previous NPRs. When the participants did have increased communication and opportunity for relationship with Buddy Nurses on NPRs, more than half (Robert, Jillian, Isabella, Aubrey, June, An, Lena) experienced this relationship as stressful and anxiety-

provoking to the extent that more than one participant used the expression "little nursing students' to describe their perceptions of their status relative to the Buddy Nurse.

As nursing students, the participants' role was to learn by assisting the Buddy Nurse in the care of his/her client. However, the participants had (directly and indirectly) received the message from BNs' tone of voice or body language (posture, gesture, facial expressions) that they were "a liability" (Jillian) , "a hindrance" (Isabella), or a bother (Robert) to the busy overworked Buddy Nurses due to their inexperience. Consequently, the participants told me that they attempted to learn as much as they could from these experienced nurses without getting in their way or annoying them in the process. Although Robert claimed that the nurses saw him as more "emotionally stable" than his younger classmates, he experienced his Buddy Nurses as "[S]cary! They are so knowledgeable, and they've got stuff to do. I knew some of my questions would be answered in two weeks in school, so I felt kinda bad bothering them" (Robert). Isabella also explained:

> Sometimes I felt like I was a burden to our Buddy Nurses because it takes extra time to teach someone and to explain things. You know, make sure that your *little nursing student* is with you to do the skill that you promised you would show them how to do. So I tried to be helpful, not a hindrance to our Buddy Nurses because there are some nursing units that say no nursing students because the nurses just can't handle nursing students. That happens. (Isabella)

Isabella felt like a "burden" to her Buddy Nurse, and her statement implies that nursing students wasted the Buddy Nurses' valuable time and tested their patience. Jillian, on the other hand, did experience some positive relationships with her Buddy Nurses; however, these positive experiences were in stark contrast to encounters with Buddy Nurses who saw her as ignorant or time consuming:

> Some buddy nurses were fabulous, and they really wanted to help you. Mind that being said, some of them were very busy, and they didn't... they kind of saw us as a liability. You know...We were these *ignorant little students* who just took up more of their time.

> We were kinda as much work as another patient. Some of them gave that impression, and some of them sort of boosted us to be a help to them. (Jillian)

Both Isabella and Jillian refer to themselves in the diminutive as "ignorant *little* nursing students" (Jillian, 2) or "*little* nursing students" (Isabella) which illustrates their impressions of being childlike in their inexperience and dependence on the nurses.

As Jillian mentioned, some Buddy Nurses who "sort of boosted us to be a help to them" used nursing students as extra help or an extra pair of hands in client care which was a status that Aubrey looked upon with some skepticism, "I don't understand why you [the Buddy Nurses] don't want me as a student because I am doing half your work. Like, yah, I'm asking you questions but I feel like I am helping you out. But people also have a sense of control. Like, it's hard to rely on a student" (Aubrey). In this way, Aubrey claimed that her learning was not valued or supported by her Buddy Nurses, despite the fact that she helped the Buddy Nurse manage client care. Aubrey had the impression that the Buddy Nurses could not relinquish control over client care. Aubrey's interest was in learning to become a nurse and the uncertainty about each new Buddy Nurse caused her considerable anxiety, "I hope[d] my Buddy Nurse is a good Buddy Nurse who likes students because there is a difference between someone who wants to teach and someone who has to teach" (Aubrey).

As a result, the participants experienced intimidation, fear, frustration, and guilt toward many of their Buddy Nurses. Most importantly, participants were often blocked from having a secure helping relationship with the BNs because they distrusted these nurses whose communication led them to feel negatively about their status on the unit.

Status Relative to the Course Leader

Nearly half the participants (An, Isabella, June, Lena, Wren) described experiences of communication with the CL as a contextual factor inhibiting their abilities to communicate

openly about grades or other aspects of nursing student performance on NPRs. Participants like An and Isabella viewed CL as a final gatekeeper in passing the NPR. An, the participant whose English was a consistent factor in his ability to pass NPRs, stated,

> The CEF brought me to the Course Leader because they say that I have to stop the course…She [the CL] makes it [final decisions about a student's grade or failure] based on what the Preceptor tells her. The Preceptor or CEF says that I am not safe to practice and tells that to the Course Leader. (An)

Therefore, An perceived that the CL enforced the opinion of the CEF or Preceptor by acting as a final judge and jury of his performance. An was given a moment to state his case before the CL decided if he should repeat the rotation. In this way, An felt that the CL had tremendous power over him.

Isabella complained of a Course Leader who changed nursing students' final grades for the NPR:

> Sometimes it seemed like the Course Leaders were these all mighty gods who came down and changed our clinical grades even though they hadn't been there. One particular CL, I heard again and again students say about a Course Leader that the CEF gave them one grade and then this CL changed it. At least ten times this happened, and they were all so upset about it... So I think that was discouraging for students...their CEF agreed that it should be an A, but this CL did not agree with that, so they got a B+. I dunno, that just seems bizarre to me. If a Course Leader is not at the clinical site or maybe sees students for maybe 2 minutes of the whole clinical rotation because they came and sat down to talk to us…how do you know what's going on? You don't. (Isabella)

Isabella felt that their performance should be evaluated as nursing students on evaluation measures designed for students. The fact that Isabella and several other participants in this study felt that CL were not present nor cultivated relationships or communication with nursing students on NPRs exacerbated this circumstance.

Some participants also perceived that CL was the final authority in miscommunications and disputes between nursing students and CEFs. When Wren and June had approached their

CLs with concerns about their CEF's teaching performance, both participants experienced their concerns being ignored. Wren was part of an NPR group who had a "bad CEF", so the group decided to wait until the end of the NPR to approach the CL. They "filled in our evaluations and said to the CL as we handed them in, 'We are more than willing to talk about what is in these evaluations', but we just got shot down. She [the CL] said that you need to learn to take constructive criticism and nothing really came of it" (Wren). June had disagreed with a CEF's evaluation of her performance, so June:

> did email the Course Leader about that [disagreement with CEF's evaluation of her]…I didn't know exactly who she [the CL] was. I mean, I knew her name, but I wrote to her about it…But there wasn't anything really ever done about it. It wasn't really a big conflict, so it wasn't really a big deal…Nothing was done with it, so I just thought, 'Okay, I'm done with it'. I had just given in and was done with it. (June)

Therefore, June felt it was best to "give in" rather than pursue the concern. Wren and June had received mixed messages about the trustworthiness of CL to advocate on their behalf. The implication was that the CL would support the CEF over the nursing student. Given the demands of the nursing program and their lack of power, the perception was that the best use of their energy and time was to let any complaints about a CEF go and keep moving forward in the program.

Jillian described a situation in which a CL had used her status as an educator at the orientation to NPRs, to remind Jillian and her classmates of their place in the hierarchy. This CL did so by mocking previous students' mistakes on NPRs:

> Most Course Leaders in our orientation did a good job of making it seem manageable. Going over, this is what we are going to expect. If this doesn't work, this is what we can try. Kind of making you feel better about it. But the one [Course Leader] wasn't so positive about it, and I wasn't the only student who felt this way about it because I talked about with other students later. She kinda went up there and told a lot of stories about students in the past and the stupid things that they had done. Like stories…and she'd kind of laugh at the end of them, just like things that students had done that she thought was

> ridiculous.... And then…and don't you dare do what this student did because once upon a time a student did such-and-such…Ha ha…Well, I don't want to make any mistakes when she's around or I'll be the punch line next time! [laughing]...it's okay to bring up examples of students and how they have done stuff. It's how we sometimes learn. But it makes a big difference how you bring it out.... if the students had been the heroes of half the stories maybe [it would be okay] but they weren't the hero of any of the stories. So, that makes it kind of hard. (Jillian)

Hence, Jillian and her classmates had interpreted this communication as the CL using stories of past nursing students as threats, rather than opportunities to learn. Jillian felt the CL's message was 'do not make us deal with the same foolish mistakes of past nursing students'. Jillian and her classmates had discussed this CL's approach to orientating them to the NPR because they felt threatened by the lack of compassion or understanding shown to previous nursing students.

In sum, the participants experienced CL as authorities whom they perceived to have power over them and whose influence was threatening to their progress in nursing education. The communication and relationships with these nurse educators was challenging for the participants as a result. The participants described encounters which had eroded their trust in CL.

Nursing Student Status: Being "on the Bottom Rung"

The majority of the participants were aware of their status on the unit relative to their clients and the nurses, and they could articulate their position as nursing students. Participants like Wren and Sophie explored when they perceived that they had had power and when they had experienced powerlessness. Wren eloquently explained her shift from an authoritative role with her clients to being at the "bottom rung" with her colleague:

> ...when you are a nursing student and go into a patient's room, especially if you are a young and inexperienced nursing student like me, you assume this authoritative role and are expected to be able to have this professional authoritative way of dealing with people. Then as a student nurse when you turn around and interact with these nurses who 'eat their young' and the doctors, you have to switch to quite a submissive…at least not everyone does…but if you don't want any clashing, you have to switch from your

> authoritarian position in the room to your quite bottom of the ladder position, below the health care aides, below everyone, outside of the room. That's tricky! (Wren)

Within the clients' rooms, Wren claimed that she was expected to play the part of a competent knowledgeable nurse whom the clients could trust to provide the best possible care. Within the corridors of the wards and the break rooms of the units, Wren told me that she played the part of the lowest health care professional on the unit, the nursing student. Wren did not question these two conflicting positions. However, she did struggle to communicate across these two statuses to advocate for her clients:

> It wasn't being at the bottom rung [as a nursing student] that was difficult for me. It was having to balance being at the bottom rung and being authoritative. So you are at the bottom rung, but sometimes you have to advocate for your patient or even just assertively communicate with the other health care professionals to make sure that your patient gets the basic stuff. That was what made being at the bottom rung difficult. To be able to advocate for your patient without stepping on toes. And I am not good at being assertive and asking for things. (Wren)

Thus, to take a credible (authoritative) stance with the clients, Wren felt that she had to challenge her submissive or subservient position with the nurses and other health care providers. The result was that either the client or health care provider was displeased with Wren; either the client's needs were not met or Wren risked offending the other nurses. Sophie struggled to find an assertive voice when in this position of limited power, and Sophie described how she had internalized this conflict:

> I had a very dominant, bold, courageous, confident, but compassionate CEF. I still think of her sometimes when I am dealing with an ethical issue that where you need to go against the grain and say to a doctor like... "what's happening here is not okay." She would go against...and not have any problem with conflict...and I certainly do. I have a hard time confronting that way. So I really looked up to her that way and tried to pull that from her personality, so I could learn from it...And I think that I take on the shame that goes with conflict. I doubt myself with the guilt. So, just recognizing when it's happening and not taking it personally, I actually feel that through this program and my Sr. Practicum in particular, was able to see the positive edges of conflict. And when it

> happened, it was turmoil in the moment, and then things clear up from there. So just getting more comfortable with that turmoil. (Sophie)

Sophie had admired this nurse's ability to confront other health care providers on behalf of the client because she felt she could not bear the guilt of offending or hurting others with her words or actions. Sophie was authentic in her interpersonal communication and relationships as a nurse, so she was vulnerable within conflict with the nurses. Stated another way, Sophie identified that she did not have a nursing persona or play the part of a nurse. Sophie was being herself which meant that she felt conflict deeply and personally as a threat to her worthiness as a person.

Wren, the participant who felt she was on the bottom rung as nursing student and subservient to the nurses on the unit, claimed that:

> ...my avoidance of conflict with the other staff changed what I was saying or what I was able to offer the patient... it was finding that balance between the needs of the patients and the needs of the other staff. So…You might present options differently to a patient based on what would avoid conflict with the other nurses. That would be my experience"..."In general, it was less actually having conflict and more of an issue of me skirting around conflict that made it hard to do the job that I was trying to do (Wren)

In other words, Wren felt caught between her clients' needs and her ongoing avoidance of conflict with the other nurses. Wren's interpersonal communication with her clients was limited by trying to appease the other nurses. Wren felt that she had not received direction in which relationship took precedence, her relationship with the other nurses or her relationship with the client.

Therefore, this notion of being "on the bottom rung" is indicative of the participants' awareness of their status relative to the other nurses and health care providers on the unit as nursing students. Challenging this status was difficult for participants like Wren and Sophie. As nursing students, they were unaccustomed to being assertive or confronting but rather were more comfortable avoiding conflict.

Making Sense of "Being Thrown to the Wolves"

There was significant variation in the ways that the participants made sense of their status and the status of nurse educators and other nurses on their NPRs. Only a few of the participants perceived that the outcome of status was power. They attributed nurses' negative attitudes, behaviours, words, or body language to their: concern about the patients (Robert), stress (Robert, Lena), insecurities in the teaching role (Wren, Kathryn), as well as workload and standards of care (Aubrey).

Robert claimed that "being thrown to the wolves", being abandoned by the other nurses to face the consequences of one's actions alone, was not a personal attack. The nurses were simply keeping the clients safe from harm, "I can understand if you screw up, they are going to throw you to the wolves…but that's because of worry for patient safety. They are not attacking you. They are worried about the safety of the patient" (Robert). However, as Aubrey explained, reporting a nurse colleague's mistake was not without consequences on the unit,

> …it's uncomfortable when all of a sudden you have to report something. I remember when my CEF did say something, it was an uncomfortable situation for everyone. I mean, the goal is patient safety, but it makes things awkward. I mean, you want to be friends with these people too. And it's awkward after that. I don't know...a lot of it wasn't even vocalized tension you could just see the tension or, like, the eye rolling. (Aubrey)

In protecting the clients from harm, the nurse who had made a mistake was thrown to the wolves. As a consequence, this nurse felt betrayed by the other nurses, who in turn, felt awkward; this anecdote is an illustration of culture on the unit.

Lena's view of the use of status and the misuse of power was compassionate. She saw nurses as individuals with personal lives and circumstances that impact their work as nurses. Although nurses care, they need support to carry out their roles within the context of their lives:

> Yah, and I think an overall understanding that we work with patients, and patients are people, and nurses go through tough times too... and sometimes it's nurses need that support as well. Maybe there are things going on at home or in their lives so work is the only place that they feel they can lash out. It's important to see that in each other...in other nurses and not just in our patients. Nurses we care! That's why we are in this job. That's why we picked this profession. I think it predisposes us to take on other people's problems, and hold that pain or stress or whatever...and if you are not able to let it out somewhere, it may come out at work. (Lena)

While Lena was not excusing the misuse of power between nurses, she tried to explain it as a consequence of nurses' need to support each other in the difficult roles that they play. Lena felt that clients' pain and stress could be contagious because nurses are at risk of reflecting or mirroring the actions and feelings of others in their environment.

Wren and Kathryn focused on nurse-educators in their explanations of the status of nurses. When a nurse educator felt vulnerable in their role or threatened by nursing students, they sometimes reacted by misusing their power. For example, Wren explained that , "[The CEF] is an official teaching role, which can make them defensive if they cannot answer a question, and if there is ever a moment when they have insecurities, that's when the eating their young comes out...so CEFs have that vulnerability that makes them eat their young" (Wren). Stated another way, a CEF may bully or mistreat a nursing student if this nurse feels vulnerable within his/her practice as a nurse educator. To illustrate, Kathryn, a mature student, experienced a change in CEF's attitude and communication when:

> One of them [a CEF], when she found out that I was older than her, I could physically see on her face that she didn't like that. I was just a couple of years older than her. After that I noticed that she was kind of harsh. Yah...Just with the things that she would say and her kind of tone of voice with me. It changed. Even now, I don't really understand why, but there was a definite change, so I didn't care for that. (Kathryn)

Kathryn's CEF had felt threatened that Kathryn was older than she was so she had attempted to subjugate Kathryn through her interpersonal communication; she wished to remind Kathryn that she was her subordinate.

Therefore, the participants made sense of their observations of nurses' communication and relationships in numerous ways. They saw their status as relative to the status of the nurses on the unit as greatly influenced by their desire to: protect the clients, manage the stress of the nursing role, and negotiate the role of nurse educator. The participants' perceptions of negative interpersonal communication of nurses with nursing students and other nurses ranged from compassionate (Lena) to accusatory (Kathryn). A few participants were able to identify the conflicting loyalties of nurses, such as wanting to keep the clients' safe yet feeling uncomfortable reporting a fellow nurse, or aiming to be an effective nurse educator, yet feeling vulnerable in this role.

Experiences of Resistance

The majority of the participants did not provide any stories, examples, or anecdotes of their attempts to resist their perceived authorities in the other nurses. However, there were two clear examples of resistance on Kathryn and June's NPRs. Kathryn used the interpersonal communication common to negative unit cultures, while June rallied help from other care providers including her CEF to meet a client's needs despite a negative Buddy Nurse.

Kathryn's resistance took the form of words and actions that would ultimately distance herself from her colleague. Kathryn described herself as a generally nice person; however, when she felt that a situation was unjust, she could "get a little bit mean" in order to "even things out" (Kathryn). She claimed that she likes "the underdog." Kathryn's resistance occurred when she was assisting a health care aide to feel residents at a personal care home. Kathryn noticed that the

health care aide was feeding a resident "with a spoon so full that I wouldn't have been able to eat a bite that big. It was huge! It was two bites for me. Seriously!" In fact, Kathryn claimed that, despite the resident's protests of "no more!" the health care aide "kept shoving it into this resident's mouth quickly" saying "just a few more bites" as if the resident were a child. Kathryn responded by saying, "Resident, are you done? You did a really good job. You're finished!" And I know I'm a student, but I don't give a rat's ass. The health care aide looked at me and she was not pleased. But you know, I don't care. She's done!" (Kathryn). While Kathryn had prevented further discomfort for the client, she had claimed that she "didn't care" that she had alienated her colleague through her interpersonal communication. While she had taken an authoritative position beyond that of a nursing student, Kathryn created mistrust and resentment between herself and the health care aide.

June's act of resistance was getting a palliative care patient up before he died despite discouragement from a Buddy Nurse and disinterest from the other staff to do so. June was on her fourth year palliative care NPR, and she claimed that she and her CEF had effective communication and relationship. She had a client was unable to get up and leave his bed, so it was a great deal of work for the nurses and unit staff to get him up. June claimed that "No other staff member took the time [to get him up], nor wanted to." In this last days, the client and his wife really wanted him to leave his bed and get up, "He wants to get up, and he can't talk either, so he writes it on the board and made motions and gestures" (June). June had noticed at the unwillingness of the staff members to get him up was impacting the client and his wife, "She [wife] was devastated. She was almost in tears every day, "Oh, he hasn't gotten up. Can we get him up?"; she [wife] was very anxious too. I can when you are in that kind of situation, it's understandable" (June). June recognized that getting up was "really the only thing left that he

could have control over, even though we had to help him get up with the mechanical lift. This was the only thing that he sort of had at this point" (June).

As a nursing student, June told me that she was not permitted to use the mechanical lift; moreover, the mechanical life is "is a two person [job], and we [nursing students] couldn't be one of them" (June). Consequently, June's Buddy Nurse refused to help her to get the client up and warned her, "Oh, I hope nothing happens" (June). Nonetheless, June elicited the help of two orderlies and "I made it happen. And my CEF was onboard with me to. She was totally supportive. That was really helpful. I dunno, it could have gone a different way if she wasn't, but she had my back on that one. So that was just compassion that I felt in that rotation. The first time in school that I felt that much of a sense of compassion. Yah. Immediately. I felt that reward. That was a rewarding rotation for me" (June). In summary, June was able to take this risk on the client's behalf with the support from her CEF. Surprisingly, her Buddy Nurse had been proud of June afterward. Although this Buddy Nurse would not help get the client up, she likely appreciated being asked for her opinion beforehand and she later recognized June's initiative on behalf of her client.

In summary, Kathryn's story illustrates her experience of resisting what she perceived as the health care aide's mistreatment of a client during a routine meal. Despite her status as a nursing student, Kathryn described herself as stepping into the interaction to prevent any further discomfort or humiliation by the health care aide. In doing so, Kathryn used interpersonal communication that contradicted that of the health care aide in front of the client. According to Kathryn, she knew she had upset the health care aide but placed little importance on the feelings of the health care aide due to the manner in which she had fed the client. In contrast, June had recruited as many nurses into her act of resistance as possible prior to taking action. Although

her Buddy Nurse had not agreed to June's plan, she did appreciate being forewarned and later praised June for taking initiative. June had elicited the help of nurses with the mechanical lift that was off limits to nursing students. Moreover, she had responded to the request of the client in contrast to Kathryn who had not been asked by the client to intervene.

THEORETICAL FRAMEWORKS: ROLE RELATED THEMES

Phenomenologist Max van Manen emphasizes "the experience of a phenomenon in a whole experience" (Dowling, 2007, p.138). In this study, the experiences of the nursing student participants did not exist in isolation; each individual's roles and circumstances were dependent on the roles and circumstances of the other(s). In an effort to balance the parts and whole as van Manen (1990)'s methodology implies, I examined nursing students' interpersonal communication using Ecological Systems Theory and Critical Systems Theory during data analysis. These two theoretical frameworks were complementary approaches in that Bronfenbrenner's (1979) Ecological Systems Theory allowed me to explore the system of the NPR wherein layers of *roles and relationships* develop the individual nursing student through communicative interactions, and in that Critical Systems Theory was a critical lens on the *statuses* within NPRs and ensuing power struggles therein.

More specifically, I identified the themes in this study across the 12 interview transcripts using the theoretical frameworks of Ecological Systems Theory and Critical Systems Theory by highlighting key words or phrases in the transcript related to *microsystem, mesosystem, exosystem, macrosystem, and chronosystem* as well as examining the data through the lens of power isolating any incidences of lived experiences of *coercive contexts* which impact on students' ability to engage in interpersonal communication with clients and nurses.

While constructing data around different types of roles and relationships with these theoretical frameworks, it became evident that themes overlapped within the systems and frameworks. Therefore, I identified the three overarching themes related to the data on the lived experiences of nursing students' interpersonal communication with clients and nurses in this study. The participants were: (1) holding on to the traditional (university) student role, (2) learning to become a professional nurse within a community of nurses, and (3) experiencing disempowerment as learners at various levels with the system. **Holding onto the traditional student role** and **Experiencing disempowerment as learners at various levels in the system** limited or hindered the participants' abilities to learn to communicate with nurses and clients on NPRs while **Learning to become a professional nurse within a community of nurses** supported participants in learning to communicate with nurses and clients on NPRs. The table summarizing all of the themes with these overarching categories is presented below and my analysis of these themes and categories follows in the accompanying theoretical framework sections.

Table IV: Role Related Overarching Themes and Subthemes

Holding onto the traditional (university) student role	Learning to become a professional nurse within a community of nurses	Experiencing disempowerment as learners at various levels within the system
Wanting control over learning • We experience fear • Falling back on life experiences **Expecting a teacher not a guide** • Negative role models • Course Leader who also teaches theory course on campus **Striving for traditional measures of achievement** • Classmates: Soldiers in white • We want the A grade • Buddy Nurses: Perceptions of the Buddy System **Learning boundaries in relationships with clients** • Boundaries with clients **Expecting to use theory from university in practice setting** • We aren't doing what we learned at the university	**Self** • Falling back on life experiences • Watch and learn **Nurses** • CEFs whom we felt built us up • Positive role models of communication with clients • Preceptors: Our mentors • Younger and Older Nurses: Generational Concerns • Experiences of Resistance **Classmates** • Classmates: Soldiers in White **Unit Culture** • Positive unit culture	**CEF** • CEFs whom we felt knocked us down **BN** • At first, we don't know much • We were "little nursing students" **CL** • CL were there but not there **Unit Culture** • Negative unit culture **Generation** Older or Old School nurses **Self:** Nursing student status: • Being on the bottom rung • How we made sense of "Being thrown to the wolves"

Ecological Systems Theory

Microsystem

Within the context of this study, the microsystem comprised the nursing students' face-to-face relationships with Clinical Education Facilitators (CEF), clients, and classmates that shaped the role of the student on the NPR (Bronfenbrenner, 1979). The interview questions related to the microsystem were: What were your experiences with your clients like? What did you find challenging and what did you find rewarding about these interactions? In your experience, what is the role of the CEF? What were your relationships with your CEFs like?

How did your relationships with your CEFs shape your experience of clinical practice? Can you give me some examples?

The participants had numerous stories, anecdotes, and examples about their experiences of relationships and perceived roles of the microsystem. The key microsystem themes are subdivided into themes related to *experiences in relationships* with Clinical Education Facilitators (CEF)s, clients, and classmates, including their experiences of their own feelings within these relationships. More specifically, the theme, (1) *We experience fear* and the subsequent subthemes of (1a) fearing the unknown, (1b) fearing they were not prepared, and (1c) fearing they would harm the client illustrate the participants' desire for more control within the learning contexts of NPRs. The participants were unnerved by their perceived experiences of not knowing that to expect on NPRs, not knowing what to say or do on NPRs, or not being prepared within class or lab beforehand. The participants expected a more structured learning situation rather than apprentice-guide learning on NPRs which I will examine further in the Discussion chapter.

The participants' experiences of relationship with CEFs led to numerous themes within the data. All of the participants spoke at length about their relationships with their CEFs whom they saw as the essential (or linchpin) relationship on the NPR in learning interpersonal communication and nursing care. CEF themes included (2) *CEFs whom we felt built us up* and (3) *CEFs whom we felt knocked us down* which in turn had the power of turning some participants on or off an area of nursing practice. According to Bronfenbrenner (1979), an individual thrives within the microsystem when he or she communicates within a number of different settings wherein relationships are formed with those who are more mature or experienced. The fact that participants experienced inconsistency in their relationships with

CEFs is indicative of the participants' expectations for a teacher, not a nurse-guide, through NPRs. CEFs are nurses, who are rarely trained as educators, nor does the Faculty of Nursing in this study provide CEFs with professional development as nurse educators beyond the yearly one day orientation to the role. The theme, *CEFs whom we felt build us up* demonstrates that the participants who had positive relationships with CEFs (nurses who are experienced or mature in their practice as Bronfenbrenner claimed in his framework) did thrive within NPRs. These CEFs saw them as learners who were valued, supported, trusted and deserving of feedback. In these ways, the participants' lived experiences within these relationships were of learning to become a professional nurse within a community of learners. However the theme, *CEFs who knocked us down* indicate that participants who did not have positive relationships with CEFs in NPRs experienced discouragement or disempowerment (to the extent that they were turned off an area of nursing practice) as learners.

The participants' experiences of relationship with their clients in NPRs yielded two themes directly related to nursing student-client interaction and interpersonal communication (4) *Falling back on life experiences* and (5) *Boundaries with clients* The first theme, *Falling back on life experiences* focuses participants' establishment of rapport and first relationships with clients while the second theme *Boundaries with clients* illustrates how the participants set parameters on the nursing student-client relationship. In the first theme *Falling back*, some participants like Danielle or Wren lacked the kinds of life experiences that prepared them to approach and build rapport with relative strangers (their clients), so they fell back on expectation of the traditional student, that is wanting structured educational preparation for these interactions. In contrast, other participants like Isabella, June, and Robert, had life experiences in service industries upon which they could fall back on in communicating with clients and these experiences supported

their experiences of learning to become professional nurses. In the second theme about *Boundaries with clients*, the participants drew upon their personal beliefs about nursing, such as clients being treated as family members or employing nursing textbook definitions of client-nurse boundaries from the university classroom that they had internalized greater and lesser degrees. I have grouped the above theme within the category of holding on to the traditional university student role because adult learners typically negotiate or integrate their personal and professional experiences into their educative experiences, a factor which I shall address further in the Discussion Chapter.

The remainder of the client themes relate to the participants' perceptions of nurses' communication with clients as (6) *Positive role models* of communication with clients and (7) *Negative role models* of communication with clients. Bronfenbrenner (1979) claimed that "significant people" such as CEFs in the case of NPRs, shape the interpersonal relationships of a given role. The CEFs' modeling of interpersonal communication with clients impacted the participants' perceptions of learning to communicate with clients and nurses on NPRs in that their perceived positive role models were nurses whom they wished to emulate with their own clients. Participants saw these nurses as nurses who fulfilled their ideals of the communication of professional nurses. Therefore within the Themes, the participants were supported in their learning by these nurses. In contrast, those nurses whom the participants perceived to be negative role models of communication with clients were equated to be negative teachers by the participants who expected nurses on NPRs to emulate the kind of professional practice they idealized or expected through their university education in nursing. As such, this theme is organized within the Themes as the participants holding onto the traditional student role by expecting a teacher not a guide.

The theme of (8) *Classmates: Soldiers in White* was an unanticipated finding in this study in that half of the participants explained that their classmates were significant face-to-face relationships that had an impact on their relationships with their clients and nurses in the NPR. However, the meanings that they ascribed to their relationships with classmates varied from supportive friend to competitor in the quest for the best grade on the rotation. Therefore, this theme can be seen as supporting learning to become a professional nurse within a community of learners and also as linked to striving for traditional measures of achievement under the overarching theme of holding on to the traditional university student role.

Mesosystem

Mesosystems include "the interactions among two or more settings in which each developing person actively participates", in other words, it is "a system of micosystems" (Bronfenbrenner, 1979, p. 25). Within this study, the nursing student's mesosystem is constituted by the student's relationships with Buddy Nurses, Course Leaders, and Preceptors. In the case of the Course Leader, Preceptor, and the Buddy Nurse, these roles imply responsibilities and relationships to several microsystems within which the nursing student participates. Interview questions about the mesosytem are: What was the role of the Buddy Nurse in clinical practice? What was the role of the Course Leader? How did these nurses shape your clinical practice experiences? Can you give me an example of a memorable nurse who communicated effectively with clients? What did you learn from this nurse?

In the theme related to Buddy Nurses (1) *Perceptions of the Buddy System*, the participants' perceptions were that a 'good nursing students' provided care to clients without annoying or being a hindrance to the Buddy Nurses. In this way, the participants' perceptions of the buddy system were disempowering to them as learners. The fact that participants and Buddy

Nurses had limited interaction when they (the participants) didn't know much in their first rotations indicates the participants' perceptions were that the Buddy Nurses viewed the students in terms of their ability to be an extra set of hands (be useful to them in client care) rather than as learners. This viewpoint was disempowering to them as learners and is organized as such within the Themes.

Course Leader theme (2) *CL: There but not There* outlines the participants' experiences of a relationship in which the nurse-educator only interacted with the participants on their NPR when problems occurred in the participants performance or with a participants' perceptions of a CEF. The implication was that good nursing students did not raise concerns for the Course Leader but rather 'flew under the radar'. Thus, the participants' relationship and communication (or lack thereof) was most commonly disempowering to them as a learner except in the instance when a Course Leader was also the theory Course Leader.

The Preceptor theme (3) *Our Mentors* indicted a supportive relationship for the few participants who elaborated on their Preceptor-nursing student relationship. These participants saw these nurses as mentoring them to increasing levels of independence particularly in the second half of this final rotation. Hence, this relationship was supportive of the participants as they learned to become part of a professional community of nurses.

Exosystem

In this study, the nursing student's exosystem are the processes, procedures, or expectations of the faculty of nursing that the developing nursing student must adhere to on NPRs. In this study, the nursing student's exosystem are the settings which do not directly involve the nursing student as an active participant, yet the processes, procedures, or

expectations of these settings affect, or are affected by, the nursing student's ability to communicate interpersonally as part of their care (Bronfenbrenner, 1979, p. 25).

I had anticipated that participants would comment extensively on assignments as a means to learn interpersonal communication with clients and other nurses on NPRs. Therefore, the interview question related to the exosystem included: To what extent were the assignments in clinical practice helpful in learning to communicate with clients and other nurses?

However, the participants consistently dismissed assignment queries. Instead, they claimed that whether they had the opportunity to practice holistic nursing practice and whether they received a letter grade or a pass/fail for their performance on NPRs were more important to them than assignments on NPRs in learning to communicate with nurses and clients. Thus, the exosystem included the two themes(1) *We want the A Grad*e and (2) *We are not doing what we learned at the faculty*. Thus, striving for an A grade had a direct impact on interpersonal communication of nursing students with each other and with their CEFs. Participants and their classmates were measuring their performance on NPRs based on the kinds of achievement to which they were accustomed at the university. As such, this theme, *We want the A* is located within the Theme of holding on to the traditional student role.

Similarly, the environment of NPRs determined whether the participants were able to practice holistic nursing care (which is enacted through interpersonal communication), a nursing value they had been taught on campus in their theory courses. The participants in this study had perceived that the NPR was the enactment of the values taught at the university faculty of nursing and was graded based on the same measures of achievement at the faculty, the letter grade. Thus, the participants had expected to use the theory from university in their practice on

NPRs, so this theme, *We aren't doing what we learned at the faculty* is placed within the overarching theme of *Holding on to the Traditional Student Role*.

Macrosystem

In this study, the macrosystem is in reference to the influence of the nursing practice culture and the way in which that culture manifests on the specific nursing unit upon the beliefs of individual nurses, nursing students, and nurse educators in NPR and SP. This culture is regenerated and continued through the process of nursing education and socialization of nurses, at least in part through communication. The interview questions for the macrosystem were: As you complete your nursing education, what are your impressions of nursing practice/the practice of nursing? What does being a nurse mean to you now compared to what it mean to you when you started your nursing education? What were your most important lessons in nursing education that you feel prepared you to be a nurse?

The main theme within the macrosystem of *Picking up the Vibe* of unit culture included (1) *Positive unit culture* and (2) *Negative unit culture*. From the perspective of half of the participants, the expectations and norms within the unit culture had an impact on interactions between nurses and clients, nurses and nurses, and nurses and nursing students. The unit culture of the nurses on the unit was learned and interpreted through the nurses' words, body language, tone, attitudes, and relationships. The majority of the participants had experienced some form of what they identified as positive and negative unit culture. While negative unit cultures disempowered the participants within NPRs, positive unit cultures on NPRs allowed the participants to learn to become a professional nurse within a community of nurses. Therefore, these themes, *Positive unit culture* and *Negative unit culture* are distributed between two

Themes, Learning to become a professional nurse within a community of nurses and Experiencing disempowerment as learners within various levels within the system respectively.

Chronosystem

In this study, the chronosystem influenced the development of the nursing student in that, nursing education and socialization to the professional role of a nurse is a significant life transition which has an impact on the lifetime of the individual. Moreover the historical moment in time within which nursing students engaged in nursing education, 2010 to 2014 in this study, is relevant because the participants are part of a generation of nursing students, the Millennials. This generation of nursing students are learning from an aging nursing workforce of Baby boomers who may not share some of the same values or priorities (Mitchell, 2012). The interview questions that elicited the chronosystem were: Based on your experiences in clinical practice, what makes you feel excited or fearful about a career in nursing? What kinds of challenges and opportunities do you and your classmates face compared to older more experienced generation of nurses? What advice would you have for a new nursing student?

However, the participants claimed that generational differences were of less significance to them compared to the pervasiveness of the unit culture that is created through nurses' interpersonal communication and relationships. Generally speaking, the participants were more likely to experience horizontal collegiality with younger graduate nurses than 'Old School' nurses whom several of the participants saw as set in their routines, yet highly capable and knowledgeable. Therefore, relating to younger nurses is found within the overarching theme of *Learning to Become a Professional Nurse within a Community of Nurses*. Older nurses both supported and disempowered the participants' learning and growth in the participants' perspectives. For this reason, experiences with Old School nurses are placed within two

overarching themes, *Learning to Become a professional nurse* and *Experiencing Disempowerment*.

Critical Systems Theory

Critical Systems Theory (CST) was employed as a conceptual framework in this study and operationalized through the typology of communication of Habermas (1987, 1984) to explore the extent to which nursing student participants critically viewed their interpersonal communication within the hierarchical power structures of nursing roles and relationships with nurses in the NPRs and SPs (Flood, 1990; Midgley, 2000; Oliga, 1995). CST was an appropriate theoretical framework because, as nursing students learn to make affective shifts from different types or modes of being (Habermas, 1987), tensions are developed due to gaps between what an individual nursing student is able to do and what this nursing student is expected to do. As these tensions develop, nurse educators and nursing students negotiate this gap within the established hierarchies of power and communication is means by which this negotiation of power occurs.

The interview questions which elicit this information from the participants were: As a nursing student in clinical practice, did you witness or experience any conflict? Among whom? How did nurses communicate in such situations? How did you react to conflict? How did this conflict impact or influence your ability to communicate with clients or other nurses?

Several themes emerged from the data which are found in the Status section of this findings chapter. The majority of the participants provided examples of the ways that status and power were shared, misused, and enacted through communication on NPRs. Several themes emerged from the data that are found in the Status section of this Findings chapter. The majority of the participants provided examples of the ways that status and power were shared, misused, and enacted through communication on NPRs. The participants' efforts at mutual understanding

(Habermas, 1987) with the nurses incited debate about the norms or expectations of their status as nursing students relative to the CEFs, BN, or CL (claim to rightness). In comparison, the nurses' utterances with their behaviour or actions after the fact (claim to truthfulness), the participants perceived that they had little reason to trust the nurses. More specifically, participants were disempowered due to their perceptions that if they disagreed with their CEFs, the CEF would humiliate, belittle, or assign them a low mark on the rotation, hence the theme, (1) *Status Relative to the CEF* is within the overarching theme of *Experiencing Disempowerment as Learners*. Participants were disempowered when they perceived that they were a hindrance, a liability, or an ignorant time-consuming bother or burden to their Buddy Nurses, thus the theme (2) *Status Relative to Buddy Nurses* is also with within the theme of *Experiencing Disempowerment as Learners*. Lastly, the theme, (2) *Status Relative to Course Leader* refers to the disempowerment of participants who perceived that their CL had the final say on the NPR in that they held the power to change their grades. The validity claims of the nurses were, in essence, denied by the nursing student participants during these experiences.

The validity claim to truth (Habermas, 1987) represented what the participants represented their experiences of interpersonal communication with nurses on NPRs, their truth of the matter, based on the evidence of their experiences during NPRs. Their "truth" or claim to truth upon completion of their nursing education was in the theme (3) *Nursing Student Status: Being "on the Bottom Rung"*, is within the theme of disempowerment due their experiences of feeling submissive to other more experienced nurses and health care professionals on the NPR while the theme (4) *Making sense of "Being thrown to the wolves'* is a theme of disempowerment because the participants explained away or excused nurses' abuses of status or power as part of the role of the nurse (to protect the client) or the stress of the job (as a nurse or

nurse educator). Lastly, the subtheme (5) *Experiences of Resistance,* in regards to Kathryn is a theme of disempowerment, for Kathryn reproduces the coercive contexts she has experienced during her NPRs. In contrast, while *Experiences of Resistance,* for June is illustrative of an example in which June was able to resist by engaging the community of nurses on the unit over time.

The Theme of Experiencing disempowerment as learners is organized by the themes attached to the role of CEF, Buddy Nurse, Course Leader, and the topics of Unit Culture and Generation. The final subcategory within this Theme, the Self, reflects the participants' experience of their own status. These particular themes, *Nursing student status*: *Being "on the bottom rung"*, *Making sense of "Being thrown to the wolves*; and *Experiences of Resistance* (Kathryn) will be described within the Discussion Chapter as coercive contexts to the extent that the participants were reproducing the disempowerment that they had experienced on NPRs.

CHAPTER FIVE: DISCUSSION

Ecological Systems Theory (EST) and Critical Systems Theory (CST) were used to organize the findings into three overarching role-related themes. As data was constructed around different roles and relationships within these two theoretical frameworks, it became evident that themes overlapped. As a result, the Themes that emerged were: (1) Holding on to the Traditional Student Role (role stagnation), (2) Learning to Become a Professional Nurse within a Community of Nurses (role transformation), and (3) Experiencing Disempowerment as Learners (role oppression) at various levels in the ecosystem. In this Discussion Chapter, I revisit these three themes of nursing student emergence as indicated by their perceptions. Habermas's intersubjectivist approach from his critical theory of communicative action and reason is used to frame this discussion of each of the major themes. Criticisms of Habermas's approach by Derrida and Foucault are taken up where Habermas's thinking cannot conceptualize the participants' experiences with interpersonal communication. Further, I employ theory and evidence to complexify issues related to expectations, development, and disempowerment as well as nursing education. In this chapter, I also engage in the final research activity of balancing "the research context though a consideration of the parts and the whole", a requirement of hermeneutic phenomenology (Max van Manen, 1990, p. 34). In this study, this means that recognizing the lived experiences and perceptions of the participants did not exist in isolation. Each nursing student's role, relationships, and status were dependent on the roles, relationships, and statuses of others in the Nursing Practice Rotation (NPR) and the larger system of nursing education. Therefore, each of Themes shall presently be considered and theorized upon and discussed in theoretical and evidentiary context in order to reflect on the research questions in the final part of this chapter. Chapter Six provides recommendations for practice in nursing education.

SHIFTING ROLES AS NOVICE NURSES

Chapter Four identified three overarching themes using the theoretical frameworks of Ecological Systems Theory and Critical Systems on the lived experiences of 12 nursing students' interpersonal communication with clients and nurses in this study. These themes indicate that participants' development into the nursing role was a non-linear series of experiences of *moving forward* or role transformation in taking on the nursing role through positive interpersonal interactions with classmates, clients, and nurses, yet being routinely *pushed back* (or potentially held back) to the state or stage of the student by both their own expectations of nursing education (a role stagnation), and by experiences of disempowerment in interactions with nurses. In essence, this study has found that the participants' development into a nurse was experienced through interpersonal communication as an ongoing struggle to find one's place (role and status) within the relationships with clients and nurses of Nursing Practice Rotations. Although the participants' experiences were communicated as persevering through anxiety, fear, helplessness, and anger as novice nurses making their best efforts to take on the roles of nurses in Chapter Four, several participants' lacked insight into how their own expectations or perceptions contributed to holding them back from developing into a nurse. As such, the students required guidance and mentorship to become independent nurse professionals over time. In the absence of explicit instruction, the participants saw themselves as largely fending for themselves in learning to communicate with clients and nurses.

As the themes relate to nurses and nursing education, the evidence is clear that the *mixed messages* of encouragement and disempowerment from different nurses' interpersonal communication also confused and frustrated the novice nurses' development to nurses' roles. Thus, educators may have inadvertently fostered a situation in which novice nurses were unable

to engage in relationships and partnerships with clients as described and taught in the students' theory courses on campus. Ultimately, such a reality can hinder students' abilities to transition to independent nursing roles. Effective communication is based on shared understandings of the conveyed messages, which in turn, enable the construction and reproduction of meaning between speakers (Habermas, 1987). However, the discourse between nurses and nursing students, and between clients and nursing students were filtered through the students' understandings of the roles, relationships, and statuses of nurses in the ecosystem. At times, these understandings were incompatible with those of practicing nurses.

Holding on to the Traditional University Student Role

This first Theme describes the expectations as novice nurses learning in the nursing practice environments of NPRs and their development in the nursing role. The first Theme describes the expectations of novice nurses learning in the nursing practice environments of NPRs and their attempts to use communication to develop into the nursing role in each new area of nursing practice (gerontology, maternity, community, surgery, or palliative care to name a few). For Habermas, communication is not simply about transmitting information from one speaker to the intended recipient. Rather, communication is a means of establishing relationships with others, what Habermas called *normative relationships* (Habermas, 1987). Thus, participants' communication was aimed at trying to realize the normative relationships between nurse and client, as well as, nurse and nurse.

To understand one another, Habermas (1987) argued that the listener must be able to follow the reasoning that is behind the speaker's assertions or *claims* (i.e.: what makes statements acceptable for the speaker). Further, Habermas argues that language and meaning are by nature *transparent* and aimed towards a consensus of understanding and action. In this way, the

participants' expectations of the social-intersubjective role of the nurse (that is, caring for others and achieving a mutual understanding with clients and nurses about what it meant to be a nurse) were transparent and aimed at consensus with the nurses and clients. However in the present study, the nurse educators' norm-guided communicative actions, their reasoning and claims, frequently lacked transparency for the participants. These novice nurses were unable to see the reasoning behind the nurses' claims. As a result, the nurse educator and nursing student (and to a lesser extent, the nursing student and the client) commonly failed to arrive at a mutual understanding as to the role of the nursing student as a novice nurse. This first Theme demonstrates the lack of transparency and consensus that led participants to feel they were floundering in the role of the novice nurse to the extent that participants drew upon long established reasoning and learning strategies of the traditional university student.

French philosopher, Derrida (1988), has criticized the work of Habermas by asserting that one cannot control how his or her communication is understood by others. No matter how much discourse, the back and forth between a listener and speaker in an attempt to understand each other's reasoning, no one can be certain that mutual understanding has been achieved (Derrida, 1988). Thus, Derrida argues that fully understanding another's intentions or reasoning is unobtainable; the colloquial phrase "let's agree to disagree" (and get on with the task at hand) is largely what became of the participants in their nursing practice rotations and led to role stagnation. Nursing students' maintained their normative relationships of the traditional university student without gaining a mutual understanding with the nurses whose role it was to socialize and acculturate them into the lifeworld of nurses.

On each new rotation, the participants' understandings and experiences of interpersonal communication were a reflection of their attempts to gain a greater sense of *perceived control*

with the requisite interpersonal communication to interact masterfully with nurses and clients on each NPR. Perceived control is defined as the individual's belief that he/she is capable of determining his/her behaviour and influencing his/her environment to create the desired results (Wallston, Wallston, Smith, & Dobbins, 1987). In essence, a dissonance frequently existed between the participants' *idealized self* as a nurse (McCall & Simmons, 1978) and the *situated self* as a nursing student whose identity in the context of the NPR was based on situational forces and cues from others (Farmer & Van Dyne, 2010). The Themes, Wanting Control over Learning; Expecting a Teacher, Not a Guide; Striving for Traditional Measures of Achievement; Learning Boundaries with Clients; and Expecting to use Theory (learned in classes) from the University in the Practice Setting (See Table Four: Role Related Themes in Chapter Four) demonstrate the participants' views of themselves as left to fend for themselves, out of control, or in a freefall on NPRs because they wanted a teacher, not a mentor or guide. Essentially, the participants were still using a theoretical orientation to approach interpersonal communication on NPRs and expecting ideal achievement in interacting with clients and finding their professional boundaries with these clients. Nursing students most acutely experience the theory-to-practice gap when they are unable to apply theory to the clinical situations they encounter in practice (Sharif & Maoumi, 2005).

Wanting Control over Learning

In face-to-face interpersonal communication between the nursing students, and nurses and clients (the significant others at the m*icrosystem* level of the system according to Bronfenbrenner, 1979), nursing student participants' struggled to adapt to or assume the role of a nursing student within the practice setting. Many of their relationships with nurses and clients did not give shape to nor facilitate the activities and interpersonal relationships of the nursing

student role, particularly in first NPRs. The consistent lived experience of the participants was that (a) learning and interpersonal communication on NPRs was a "sink or swim situation" (Robert) that they were "thrown" into (Jillian), and that (b) their fear took various forms including anxiety, stress, terror, and feeling paralyzed. The participants repeatedly claimed that they had not known how to approach the role and the responsibilities of the nursing student.

Most importantly, participants voiced their expectations to know how they should behave, what they should do, and what they should say to clients and nurses on NPRs. The principle concern among the participants was: what am I *supposed to* do and say to clients and nurses? In other words, they wanted to know explicitly what was required of them. In short, they were expressing a desire for clear expectations, in the form or rules or instructions from the authorities on the unit, the nurse educators and the nurses which is a reflection of their development as novice learners who were trying to cope within a new role and status on each rotation.

Those participants who had little to no prior personal or professional experience in communicating with relative strangers or in intimate contexts depended upon other students or nurses to help them interact with clients. The expectation among these participants was that they should have received some guidance, direction, or concrete instruction in what to say or how to behave with clients prior to starting each NPR. Given the varying degrees of any client's condition, expectations of care, acuity or chronicity of the condition, awareness of time and place, and personality, this expectation may have been somewhat naive. At the same time, it is established in the literature that novice learners commonly cling to facts or rules to shape their behaviours because their performance and experience is limited (Benner, 1984).

This study could lead educators to believe that nursing students should have NPRs of longer duration with consistent guidance from nurses who can 'show them the ropes' (mentor and coach them) in regards to the rules, procedures, best practices, including interpersonal communication in the role of the nurse. Should a nursing student have opportunities to build relationships with clients and healthcare providers over longer more interconnected placements in contrast to the compartmentalized NPR clinical model in this study (Roxsburgh, Conlon, & Banks, 2012)? In reality, the present study has shown that the nursing student's relationship with a CEF can (and has) the capacity to turn a student off an area of practice which raises the question of why a student should remain in such an NPR for a longer period of time if that student is not learning within this significant relationship. Development of the novice nurses in this study was hindered more in interactions with nurses whom the participants felt were 'picking on them' than in the absence of guidance (wherein nursing students had to figure out how to 'pick up' communication on their own through trial and error, or with the help of classmates).

Therefore, the participants in this study, to varying degrees, described their efforts as novice nurses to gain a perceived sense of control within their role as nursing students by attempting to pin down and pick up the "right" interpersonal communication to credibly enact the role of the nurse by the end of each NPR. If the NPR had nurses whom the participants' viewed as unhelpful in their development as novice nurses, this experience had the potential to turn them away from an area of practice and lose opportunities for exposure to nurses' roles in this area.

Pinning down the "right" communication behaviours and skills. Due to their limited experience within nursing practice settings, the participants were looking for rules or instructions that they felt would give them a sense that they were getting nursing care "right," or that they

had some control over their learning. As such, they perceived their client interactions in light of their learning as nursing students rather than as novice practioners (Benner, 1984). Similar to Benner's (1984) description of novice nurses who relied on rules to make clinical judgements in practice, the participants attempted to use the rules they knew as a student to guide their performance on NPRs, particularly when they felt that the guidance from nurses was absent.

Participants' comments demonstrated that they understood interpersonal communication to be concrete "caring" behaviours or skills possessed by nurses that they could identify or *pin down* and use in their own interactions with clients. In their descriptions of experiences interacting with clients, participants deemed caring behaviours to include holding a client's hand (Kathryn, Sophie, Jillian), helping a client with her sweater (Aubrey), getting a client a warm blanket or cup of tea (Lena), continuing to speak to clients who were unable to respond (Isabella), or helping a client out of bed (June). Moreover, several participants perceived communication to be a set of tangible skills they had to acquire to introduce themselves to the client, ask questions, clarify information, listen actively, and provide information with the body language and demeanour of a nurse. Consequently, participants understood that these caring behaviours and skills of interpersonal communication built and sustained rapport with clients. The implication was that, if they could pin down the specific behaviours and skills that the nurses used with clients, they could take on the role of the nursing student. In these ways, participants had perceived interpersonal communication to be concrete and specific behaviours and skills with predetermined "right" or "best" words, body language, and behaviours in a given client interaction.

Most commonly, participants experienced interpersonal communication with their clients within the perception that the nursing student's role was to practice nursing behaviour or skills

on clients. To the extent that one participant claimed "I don't remember a lot of individual patients actually. You know, it was more about trying to get the skills done and trying to learn to do them throughout the day." In this view of clients as 'practice' for nursing students, communication becomes something that nursing students do to the client who is expected to comply with the nurse, rather than establishing therapeutic relationships, a point that I touch on later in this chapter.

This finding is supported by research acknowledging the difficulty of nursing students to prioritize effective interpersonal communication when both nursing educators and students are "preoccupied with their perceived lack of knowledge and technical skills" (Beckett et al., 2005, pp. 28-29). When skills are prioritized over human interaction, nursing students frequently develop *mechanistic relationships* with clients in which students are more focused on their own learning of nursing psychomotor skills than the needs of the client, or they consciously or unconsciously cultivate *authoritative relationships* with clients wherein the student makes decisions in care based on what he or she believes to be best for the client (Suikkala & Leino-Kilpi, 2005), thereby assuming the client's agency. Likewise, interpersonal communication for several of the participants was viewed as set of caring behaviours and skills rather than the cultivation of effective working relationships or a partnership with clients who have a say in their own care which are notions and values taught in theory courses. While some participants were fortunate to have guides or role models in the nurses who enacted the values of nursing practice, others had nurse educators who disempowered them in this regard.

In summary, the participants' understanding that interpersonal communication was largely as a set of concrete "caring" behaviours or skills possessed by nurses that could be identified and pinned down in order to enact the role of the nursing student. The perception that

interpersonal communication is a set of scripted routine skills and behaviours gave the participants as sense of perceived control over their learning on NPRs which is a reflection of their stage of development in learning to become a nurse (Benner, 1984). Unfortunately, this understanding of interpersonal communication led them to interact with clients as authorities who were performing another skill on the client rather than working in partnership or relationship with their clients.

Picking up interpersonal communication. In the findings, participants had consistently identified that they were not formally taught to communicate through instruction at the university or during NPRs but rather had learned to improve their interpersonal communication with clients and nurses through trial and error and by watching the other nurses on the unit. In essence, they had determined that one of their roles as a nursing student was to learn or *pick up* interpersonal communication by observing (a) the nurses' role model communication with clients (as evidenced by themes about the participants' positive/negative role models of communication in nurses), (b) the nurses' communication with each other (as demonstrated by themes related to the participants' experiences of positive/negative unit culture), and (c) nurses' communication with nursing students.

The consequence was that several of the participants' comments in the interviews about the acquisition of interpersonal communication on NPRs reflected their lived experiences of having to pick up communication without formal instruction. For example, "I think it's difficult to teach communication" (June) and "To learn communication, I think you should try to observe what others are doing and try to do the same thing" (An). As a result, most participants identified that the nursing students' role was to pick up what they could from the available models of

interpersonal communication among the nurses on NPRs. Attempts to pick up interpersonal communication gave them a sense of greater perceived control of their learning on NPRs.

The concern with interpersonal communication as learned through social interactions is that the participants had a significant amount of communication to pick up as nursing students. First, participants consistently claimed to improve their interpersonal communication by picking up words, phrases, or behaviours of nurses whom they perceived to be positive and negative models of interpersonal communication with clients. In these instances, inexperienced nursing students decided which nurses' interpersonal communication to pick up and mimic in their own interactions with clients. Without guidance, participants may not have understood comments or behaviours in context, nor may they have chosen to emulate communication that was appropriate beyond that unit context. Second, the participants learned to pick up the "vibe" (June) or tone of the interpersonal communication between the nurses on the unit. Participants described how they learned, to a greater or lesser extent, to "feel out" (Lena) the unit culture through the nurses' words, tone, attitudes, and behaviours in order to adapt to the unit and establish communication, relationship and rapport on the NPR. As a result, some participants had merely survived on the unit while others were able to adapt to unit culture for the length of the rotation. Third, as learners, the participants had to pick up the teaching and communication styles of the Clinical Education Facilitator (CEF), Buddy Nurse (BN), Course Leader (CL) or Senior Practicum Preceptor (P), and other nurses on the unit of varying generations. Picking up on nurses' interpersonal communication allowed the participants to establish who would take the time to help them, who had the energy or skill to guide or mentor them, or who would challenge them or act as gatekeeper. In these interactions, the participants picked up their status on the given unit. Unsurprisingly given all they had to pick up, participants identified that the lack of preparation in

interpersonal communication had inhibited their abilities to communicate with nurses and clients on NPRs, and several of their interactions with clients and nurses were fearful, paralyzing, and anxiety provoking experiences.

In contrast, the nursing education literature has firmly established that the teaching and learning of interpersonal communication in nursing education must be deliberate. In other words, communication must be explicitly taught by nurse educators, that is, nurses who have the experiences of professional development from interpersonal communication (Boschma et al., 2010; Krautscheid, 2008; San Miguel, Rogan, Kilstoff, & Brown, 2006; Üstun, 2006), as it is currently recognized that communication skills "are not innate" (Griffiths et al., 2012, p. 126). Communication must be unambiguously practiced by nursing students in directive practice tasks, exercises, and assignments prior to (and upon) entering clinical practice settings. Lecture content on interpersonal communication theory or strategies is not effectively applied by students in clinical settings without practice, for "Telling students how to communicate provides theoretical knowledge about the mechanics of communication, but lacks practical knowledge and application when, what and how to communicate information" (Krautscheid, 2008). In other words, there is a need for both the theoretical and the practical learning about interpersonal communication in the form of a meta-approach.

Therefore, participants' efforts to pick up the words, phrases, and behaviours of nurses, the unit culture, and their nurse educators was also an attempt to gain control over their learning within the nursing student role, yet the unpredictability of the health care contexts of NPRs cued their fear and anxiety on NPRs. This need to control and need to get it right is connected to their vulnerability as nursing students and speaks to their lived experiences of feeling powerless in this role of the novice nurse. The present study had found that the expectation of nursing students

being responsible for picking up this interpersonal communication without guidance is unrealistic given their novice status as nursing students.

Expecting a Teacher not a Guide

Participants had expected nurse educators on NPRs to take the role of the teacher like at the university rather than the role of a guide in practice. The participants' expectation for a teacher, not a guide through NPRs, transpired primarily at the face-to-face level of the m*icrosystem* in the CEF-nursing student relationship although participants also expressed their desire for the Buddy Nurse (BN) and Course Leader (CL) to act as a traditional teacher (a role which the participants were familiar with from formal education). The nursing student and BN/CL relationships occurred at the m*esosystem* level of the system, for these nurses had relationships with several microsystems within which the nursing students participated.

More specifically, the participants wanted experienced CEFs on NPRs who were familiar with educating nursing students on client cases, processes, procedures, as well as interacting with clients and nurses on the rotation. In the case of a BN, they presumed that they would work with BNs who had experience teaching nursing students on the unit. Several participants expressed their appreciation for seasoned nurse educators "who knew what they were doing", as Meredith explained, for "The experienced CEFs know where we are coming from, and what we do and don't know. They tailor how they teach us...so having an experienced CEFs who have done this over and over again and they are a known fixture on the unit as a CEF with a group of students made a huge difference" (Meredith). The case of the CL who also taught the accompanying theoretical course at the faculty shows that the participants had their expectations for teachers met in an educator who bridged the theory and practice, and who acted as a support and resource for them in their learning. Alternatively, the participants may have also had the opportunity to

cultivate a relationship with the CL on campus prior to the NPR, so they felt safer with such individuals.

In contrast, the participants had known when a CEF was inexperienced, and their reactions ranged from being amused by a CEFs lack of experience to feeling shortchanged by it, as evidenced such comments as "She was brand new to the job. Never done it before. We were learning together. It was quite entertaining. She was pretty lenient with us...about assignments and stuff," (Robert) and "I worked with a nurse who was very...scattered. It hindered my experiences and she didn't really communicate very clearly what she expected me to do" (Sophie). In other words, the participants perceived that they were dedicated to their learning on NPRs as nursing students and expected an equally proficient, committed, and enthusiastic teacher to give them clear instructions, useful feedback, and concrete directions. The participants expected the CEF, the BN, and CL to be the link between the clinical lifeworld of the nurses in professional practice and the academic lifeworld of the university.

Whether the participants appreciated the individual CEF, BN, or CL (or not) on NPRs, they repeatedly recognized the importance of this teaching role in their education as nurses. The participants were enthusiastic (and fearful) on NPRs because they had recognized that nursing students learn to perform as nurses on NPRs, and interpersonal communication with CEFs and BNs is a key part of the learning process of the students. Due to the 6:1 learner to teacher ratio on NPRs, the CEF cannot be present for all of the nursing students' learning on the unit; therefore, CEFs also rely on BNs to teach students. Several of the participants identified this circumstance. For example, June told me that the nursing student's relationship with the CEF and BN "is huge! You need that. It's like your backbone almost. There is always questions coming up, and sometimes your CEF is busy and you rely on your BN too. You know you need them"

(June). The participants were aware that on NPRs, the safety of the clients and the nursing students is dependent upon the availability and the knowledge of the nurse educators on the unit (i.e.: at the m*icrosystem* level) (Jones et al., 2007), so they expected competent, available, and engaged teachers. This expectation is likely a reflection of their status as nursing students; they expected to take the role of the learner who is directed by an expert teacher. However, expert nurses are not to be assumed to make expert teachers of their expertise.

The participants' expectation of a teacher must be explored within the context of nursing education at the e*xosystem* level, the policies, procedures, and expectations of nursing education and the profession. The participants in this study were on NPRs two consecutive days a week (on average) for the majority of their nursing education. On the other weekdays, they learned at the university in theory courses or skills labs with nurse educators, the vast majority of whom had *left* nursing practice to engage in teaching or research at the university in this study. These nurses were content experts who rarely had formal education in how to teach, but rather, most commonly learn to teach through a process of trial and error, available faculty development on teaching, or mentoring at the university. Several participants in this study recognized the contrast between the more seasoned and experienced nurse educators at the university, and the less experienced nurse educators on NPRs. If a university based nurse educator is struggling to communicate his or her knowledge or experience in the classroom, no one dies, no codes are called, and no incident reports are filed in the way that errors are responded to or reported in hospital, for instance. Nurse educators at the university do not bear the risks and responsibilities that BN or CEFs do in care settings. That is, client care takes precedence over all other activities (including teaching and learning). As a consequence, teaching and learning is subject to the nature of the unit at any given time and secondary to client care needs. The price as a nurse

educator at the university is that full-time nurse educators take a substantial salary cut when leaving full-time professional nursing practice to teach at the university. Moreover, the demands of nursing education at the university institution allow a rare few nurse educators to maintain a professional nursing practice "on the side." Paterson (2003) has argued that the result is that nurse academics and educators "may feel distance from the realities of clinical practice" while staff nurses in the practice settings "may feel distain for educators lack of relevance to real world nursing" (p. 23). Nonetheless, both university nurse educators and practicing nurses struggle with the advantages and challenges as educators in their respective roles.

In comparison, the participants unanimously recognized that nurses who educate nursing students within practice settings are rooted in their practice and routinely engage in interpersonal communication with clients and nurses in health care settings as clinicians, yet they are frequently inexperienced at teaching nursing students (which becomes apparent in nursing students' interpersonal communication with them). Hence, the participants' expectations of CEFs and BNs' teaching often went unmet when these nurses could not teach their current clinical expertise and experience in a way that reaches nursing students. Given this theory-practice gap of educators and clinicians, it is unsurprising that the participants in this study felt that they were inadequately prepared for interpersonal communication with clients and nurses on their NPRs.

Since the emphasis of nursing education has shifted from an apprenticeship in the hospital to academic settings at the university, the role of the nurse educator in practice, particularly the CEF, has become incredibly demanding, and I would argue, sets up nurses to fail as teachers in practice settings of nursing (NPR)s. In the system of present nursing education, the CEF is responsible for teaching the students, being a clinical expert, assuming the legal and ethical responsibilities of the clients, and respecting the policies and procedures of the nursing

education program (by reporting to the CL) and the health care institution. University based nursing education has changed from didactic teaching to more participatory styles of engaging students (Lorentzon, 2003) such that nursing students expect to be included in interactions with nurses on NPRs (Evans, Costello, Greenberg, & Nicholas, 2013). Clinical nurses are expected to "provide theoretical knowledge, share clinical expertise, and model professional behaviour to nursing students" (Evans et al., 2013, p. 67). To the extent that, Schuster, Fitzgerald, McCarthy, and McDougal (1997) argued, "the level of responsibility and accountability demanded of clinical nurse educators is not comparable with that required of faculty teaching in the classroom or lab" (p. 154). CEFs rely on BN to assist them in teaching students because some nursing programs have been forced to increase CEF to nursing student ratios (to as high as 10 or 12 nursing students to one CEF in some parts of the United States) due to the financial challenge the current NPRs model causes for academic institutions (Jones et al., 2007). In practical terms, student to CEF ratios must be kept low to ensure client safety, yet these low ratios translate into higher costs to employ the requisite number of CEFs for this nursing education model (Jones et al., 2007). The nursing education program in this study had 6 or 7 to 1 nursing student-to-CEF ratio. However, CEFs typically earn less as nurse educators on short-term contracts than they could as nurses in practice in salaried positions, so many nurses are unwilling to participate in professional development as CEFs or educators if this constitutes unpaid time. These are some of the factors that act as obstacles to recruit and retain effective teachers in nursing practice settings.

Several participants did recognize the inherent challenge in the CEF's role. For instance, when I asked a few of the participants if they would consider being a CEF in their career, Jillian saw the CEF role as "a really challenging job. Sometimes I feel sorry for them. Pitied them. I thought it must be hard because you can't please everybody" (Jillian). In these ways, several

participants had an awareness that the CEF or BN must, not only be experienced educators, but also resilient and strong individuals to remain in the role of CEF for the long term. I remind readers that the nursing education program in this study has had a 40% rate of CEFs leaving nursing education each year for the several decades which I would argue is, at least in part, due to their obstacles as teachers. Again, such obstacles to teaching make it difficult to recruit and retain practicing nurses as CEFs or other nurse educators in the practice settings.

Striving for Traditional Measures of Achievement

An important focus for the majority of participants was the traditional measure of student achievement at the university, the letter grade. Half of the participants identified themselves as excellent students in both the classroom and NPRs, and the majority claimed that they made an effort to achieve a high grade on NPRs. Within this theme, the impact of grades on face to face relationships between the participants and their classmates occurred at the *Microsystem* level of the system while the participants' attitudes and approaches to achievement on NPRs are explored within the c*hronosystem* level of their generation.

Competition for the best letter grades on NPRs shaped participants' interpersonal communication and relationships with clients, CEFs, BN, and other nursing students. Participants admitted that nursing students had focused more on achievement of nursing skills and tasks than on communicating with clients because they wanted to get the best grades. Like other Millennial nursing students, participants in this study saw achievement and success as highly important (Pettigrew et al., 2011) as Lena explained, many nursing students "were all about getting the A" grade. Educational scholars in post-secondary education. Howe and Stauss (2007) claim that Millennials are hyper-focused on achievement in the form of grades to the degree that they commonly request feedback before they have completed a task. In this study,

several participants saw feedback as a way to monitor their progress and ensure that they were on track to achieve the A grade. Thus, the participants' attitudes and approach towards NPRs were impacted by their desire for achievement.

Furthermore, participants admitted that communication and relationships with CEFs was often based on a climate of self-interest as they attempted to prove to the CEF that they each deserved a high grade which is supported by research (Heikkinen et al., 2003; Heikkinen & Isola, 2004) describing nursing students as competitive individuals who do not share information nor cooperate well, and experience envy towards fellow student nurses who were more successful in nursing education. If the BN was not part of the evaluation process, some participants saw this nurse as less important than the CEF (who assigned them a grade), in spite of the fact that the BN might provide unique learning opportunities. Lastly, striving to be the nursing student who got the A grade impaired participants and their classmates' willingness to communicate with each other and share information or encouragement which participants like Sophie had experienced as leading to overt distrust, conflict, or bullying between the students. Indeed, the nursing education literature provides numerous examples of nursing students bullying, harassing, or verbally abusing each other (Cooper & Curzio, 2012; Cooper et al., 2011; Cooper et al., 2009; Heikkinen et al., 2003; Heikkinen & Isola, 2004; Clarke et al., 2012) through interpersonal communication rather than developing professional communication. Thus, participants' striving for the best grade potentially inhibited the transformation of their interpersonal communication to a professional communication that resituated them from being nursing students to nurses.

The participants' desires to achieve an exemplary letter grade on NPRs must be considered in light of factors linked to their moment in nursing education at the *chronosystem* level of the system. First, entry to the nursing education program in this study was competitive in

2011 or 2012 (when the participants were accepted) and based entirely upon GPA, so the participants had to achieve a high GPA (a minimum of a B+ average) to enter nursing education. In this way, their cohort of nursing students was composed of university students who were accustomed to achieving top grades in a traditional student role. Participants in this study shared their impressions that they were competing against other top students for the available A grades on NPRs. In sum, several of the participants were unaccustomed to experiencing failure or lack of success which influenced their perceptions of NPRs (and their interpersonal communication by extension).

Second, several of the participants identified that the workload of nursing education was a contextual factor in the nursing student role that inhibited their interpersonal communication with nurses and clients. More specifically, striving to achieve excellent grades in the workload of their nursing education led them to feel overwhelmed, tired, and pressed for time for a significant portion of their nursing education. To illustrate, participants commented that they were so busy during their nursing education that they had very limited free time, for the nursing education workload took over their lives and left family members feeling concerned for their health and well-being (Jillian, Aubrey, June). Furthermore, nursing students like Lena who had fast-tracked her studies were "brain exhausted" by the final year of their education (Lena). When asked to provide advice for other prospective nursing students, Robert advised students to "Leave your social life behind. Really, you are not going to have one" (Robert). These experiences are supported by literature on nursing students' struggle to balance academic workload and their preparation for/participation in NPRs (Crombie et al., 2013). Interestingly, a study by Chernomas and Shapiro (2013) within the same nursing education program as the present study, found that nursing students experienced stress or pressure due to the workload of nursing school; the

participants in their study felt there simply was insufficient time for each task. Unsurprisingly, participants such as Sophie and Lena in the present study identified that, at times, they were exhausted, and this fatigue negatively impacted their interpersonal communication on NPRs to the extent that Lena used "red flag language and tone" in a clinical reflection (Lena), Sophie was "paralyzed" by feelings of overwhelm, and Aubrey clung to her CEFs "like a safety blanket" despite doing what she admitted was excessive amounts of research.

The amount of curricular content in nursing education is one of the most significant challenges of current nursing education to the extent that the term *content saturation* has been assigned to this dilemma (Giddens, 2007). Content saturation in nursing education has numerous contributing factors including: the rapid expansion of nursing specialization and scientific knowledge, changes in health care delivery, and the shift to the information age (Benner et al., 2010; Giddens, 2007). Essentially, new information has been added to nursing curriculums in recent decades with reluctance on the part of nurse educators to delete any pre-existing content. As a result, the nursing student experience has become "frustrating and overwhelming" due to excessive reading assignments, content processing, and memorization (Diekelmann, 2002). At the juncture in time when this study took place, the participants' nursing education program had not undergone curricular reform necessary to reduce the content of the curriculum although plans had been initiated and were underway. Therefore, the workload of the participants' studies at university and in preparation for NPRs left them exhausted and overwhelmed which in turn negatively impacted their communication on NPRs.

Nearly all of the participants perceived that they had entered nursing with intrinsic motivation, such as the desire to help and care for others. This finding is consistent with the literature that reports students enter nursing education to help and care for others (Beck, 2000;

Hemsley-Brown & Foskett, 1999; Mooney, Glacken, & O'Brian, 2008; Rheaume, Woodside, Gautreau, & DiTommaso, 2003). In this study, nursing students explicated being motivated by both intrinsic (helping and caring as an entry point) and extrinsic rewards (earning best grade as an achievement). Thus, nursing students who possess the desire for traditional forms of achievement (and seem to know no other way to learn) need to understand that their role as a nurse is to build working relationships with clients and nurses in practice. In this study, achievement of the top letter grade was the measure of success for the participants rather than growing as a novice nurse. While this approach to the nursing profession is inarguably naive, the participants' lack of experience, wisdom, or judgment also made the participants vulnerable within interactions with more experienced or seasoned nurses. This vulnerability will be examined in the final section of this chapter.

Learning Boundaries with Clients

Caring and helping are embedded in the context of professional nursing. Boundaries in nursing are interpersonal relationships professionalized by the perimeter of the nursing role. Such factors as ethics and power are involved because the nurse-client relationship is not personal but professional and formal. However, nursing students frequently understood themselves subjectively, meaning that they were commonly influenced by personal beliefs and feelings rather than an attempt to enact the professional role. Relationships and interpersonal communication related to boundaries between the participants and their clients was manifested at the m*icrosystem* level, for the microsystem is about the individual experiences and perceptions of the role and relationships in one's environment (Bronfenbenner, 1979). During NPRs, the participants had encountered CEFs, BN, and staff nurses with varying perceptions of how close or how far one should sustain a relationship with clients and how to establish varying boundaries

through interpersonal communication. The ways that participants made sense of these inconsistencies was dependent on their personal values and development as novice nurses in first professional relationships with clients. Therefore, the participants' boundaries with clients depended on how close or how far they each believed nurse-clients ought to be in the care of clients and themselves over a career in nursing. These boundaries ranged from close (treating clients like family members) to clinical or professional (therapeutic relationships). In other words, participants' first identities as nurses were, at least in part, based their first experiences of boundaries with clients.

Much of the nursing literature suggests that nursing students require substantial guidance in setting boundaries through interpersonal communication with clients because these novices, who lack the knowledge and experience to understand the clients' physical conditions and resulting emotional manifestations, are at risk of developing a selfish love for their patients (Fagerberg & Ekman, 1997), an extrinsic motivation to care. In this study, two participants (Kathryn, Danielle) claimed to love their clients or to treat them as they would family members. Other scholars (Eifried, 2003; Sorrell & Redmond, 1997) argue that nursing students often become attached to their clients if they place high demands on themselves and find it hard to forgive themselves if they make a mistake or feel they have let patients down. Similarly, several participants shared anecdotes that illustrate placing high demands on themselves to "be there" for their clients which may be indicative of their sense of responsibility towards clients or may demonstrate misconstrued care that could put novice nurses at risk for compassion fatigue (Austin, Goble, Leier, & Byrne, 2009). When inexperienced nursing students are exposed to varying models of nurse-client boundaries on NPRs, they are not able to make sense of (what they see as) the inconsistencies in the professional boundaries they observe, so their own

behaviours default to their personal values about boundaries. Interpersonal communication is highly personalized, idiosyncratic and context dependent, yet these differences were perceived as inconsistencies by the participants.

Expecting to use Theory from University in Practice Setting

As an orientation to NPRs, participants had perceived a disconnect between the values and priorities of the nurse educators at the university and those of the nurses on the units of their NPRs as to whether nurses on NPRs place greater priority on the completion of tasks over attending to the emotional, psychological, spiritual needs of their clients on a busy unit. At the university faculty, the participants learned about holistic nursing care as a valued attitude, a behaviour, a philosophy, and way of being in which the nurse communicates, not only factual information about the client's diagnosis and treatment, but also shares emotional information with the client by being attentive to the client's non-verbal communication, listening to the client's inner experiences of the disease or condition, asking about the client's support systems, coping strategies, and cultural beliefs (Weaver, 2013). Participants experienced guilt, sadness, frustration, and concern due to their perceptions that being a nurse meant enacting hands-on nursing skills to get anonymous clients through the health care system as quickly as possible.

Participants' perceptions about what they saw as limited or rare holistic nursing practice were narrow in scope; their perceptions existed at the *micosystem* level between nurses and clients when the problem originated at the *exosystem* level of nursing education and practice, the policies, procedures, and assignments of nursing education necessary to meet the Standards of Nursing Practice set by the College of Registered Nurses. More specifically, participants' comments were not framed within an understanding of the concerns of the unit, institution, or Canadian universal health care system related to the impacts of such factors as: staffing

shortages, mandatory over-time, shift work, patient load, financial restraints, patient acuity, violence or abuse against nurses. Nor were the realities of nursing care in the 21st Century discussed including increased chronic illness, changing demographics and multicultural clients, and scientific and technological advances (Forbes & Hickey, 2009). Within nursing clinical practice realities of high patient acuity, staff shortages, and time constraints, biomedical considerations are prioritized and interpersonal communication becomes non-essential (Beckett et al., 2005). In these circumstances, nurses' hopes of communicating holistic care were clashes within the larger realities of nursing at the level of the *exosystem*.

However, the gap between the participants' lived experiences of nursing practice and interpersonal communication at the university and in NPRs is deeper than their experiences as novice nurses. When nurse education shifted from the hospital based diploma programs to the university, a tension was created between (a) the university's expectation of independent thinking and (b) the nursing practice institutions' expectations of organized, efficient, competent, and complying workers (Brennan & Timmins, 2012). At the university, nursing students are taught to compassionately respond to the individual needs of clients, to become judicious critical thinkers, and to provide care safely and accurately in health care contexts wherein knowledge and innovation are constantly improving (Benner et al., 2010). This approach is a departure from an apprentice-based training model in hospitals where routine tasks and hands-on care were the emphasis (Henderson et al., 2012). For decades, researchers have expressed concern about the education-practice gap, and pointed to the practice settings to adopt the nursing science and values taught within baccalaureate nursing education programs in universities and colleges. More recently, scholars such as Benner et al. (2010) worry about the practice-education gap, that is, baccalaureate nursing programs' abilities to prepare students for the realities of the profession.

Benner and colleagues (2010) observed a "fragmentation" in nursing education between what students learn in the classroom, skills lab, and NPR (p. 78). Understandably, participants in this study approached NPRs as a university student rather than as an apprentice or novice nurse in the hospital based programs, which in turn, led them to expect to use the theory from class in practice.

The first Theme, Holding on to the Traditional Student Role illustrates that differing expectations occurred, particularly between nursing students and nurses on NPRs because due to the participants' inexperience or because of systemic *exosystem* level challenges. Overall, the participants were not aware of impact of the *exosystem* on their perceptions of their interpersonal communication and relationships with their nurse educators in NPRs. Rather, participants operated within a narrow point of view or scope according to what they felt they needed as learners on NPRs. As a result, much of the responsibility for the participants' concerns and nursing education's shortcomings fell on the CEFs, and to a lesser extent, the BN. These contrasting perceptions played out through interpersonal communication.

Learning to Become a Professional Nurse within a Community of Nurses

This second Theme summarizes the positive lived experiences that led participants to feel like they were becoming nurses and were part of a community of nurses, a role transformation. In this way, the participants became part of the *lifeworld* of nurses, a shared backdrop of shared assumptions, background knowledge, and meanings on the basis of which (nurses, in this case) reach consensus (about the roles, relationships, and status of nurses) (Habermas, 1984). Stated more simply, the lifeworld is a form of unity (Thomassen, 2010) among nurses. Hence, the lifeworld is reproduced through communication, and as this Theme will show, has the potential to renew and transmit nursing culture, create solidarity among nurses, and shape the identity of

nurses if participants developed relationships with nurses whom they perceived to model positive identities of nurses and interpersonal communication as nurses, build them up as novice nurses, and help them belong on the culture of the unit.

Further, Habermas (1984) argues that communication reproducing the lifeworld is egalitarian, in that discourse (attempts to understand each other's reasoning through communication) occurs due to the full and equal inclusion of the actors. In the present study, this sincere and inclusive dialogue was most egalitarian among the nursing students themselves. As this Theme will demonstrate, the friendships among the nursing students held as much importance to becoming part of the lifeworld of nurses as relationships with nurses.
These experiences occurred in interactions between the nursing student and client (*microsystem*) level), nursing student and CEF (*microsystem) or BN, CL, or P (mesosystem)*, and the nursing student within the unit culture (*macrosystem)*. This Theme consistently extends existing research about nursing students on NPRs in the themes related to: self, nurses, unit culture and classmates.

Self

Participants' initial experiences of the self (as a nurse) was in nursing student-client interactions at the level of the *microsystem*. Participants' prior life experiences influenced whether they fell back into the expectations of a student (who wanted clear instructions and explicit guidance in interpersonal communication) or whether they fell back on prior interpersonal communication experiences (and used those experiences to interact with clients in ways that supported their nursing). Traditionally, nurses have considered nursing students with prior life experiences, such as mature students, to be an asset on NPRs (Deogh, O'Brien, & Neenan, 2009) because they have often cared for others, possess an understanding of the realities of nursing, and have developed their interpersonal communication skills (Montgomery et al.,

2009). This aspect of self represents the participants' first approaches to interpersonal communication in the role of a nursing student who was taking first steps to be part of the nursing profession.

Whether a participant had prior life experiences necessitating interpersonal communication or not, all of the participants attempted to improve their interpersonal communication with clients by *Watching and learning* from the other nurses interact with clients on the unit. In other words, they looked for themselves as future nurses among the nurses on NPRs. These nurses were their models of the possibilities for their identities as nurses. The relationships that the participants had with these nurses and the learning they gained from these nurses was created and sustained through interpersonal communication between the nurse and nursing student.

Interestingly, participants consistently described the interpersonal communication in these nurse-nursing student relationships using the language of dualistic opposites. More specifically, participants perceived that their interpersonal communication with nurses *either* empowered *or* disempowered them as nursing students. For example, participants described nurses' empowering interpersonal communication (open, receptive, positively reinforcing, useful, provided perspective, supportive, trusting, advocating, inspiring, used touch appropriately, managed emotions, and bridged theory and practice) in contrast to nurses' disempowering interpersonal communication that was (blunt, intense, unprofessional, hovering, disinterested, distant, absent, blaming, unhelpful, dominating, discouraging, intimidating, untrusting, controlling, set in one's ways/routines, blaming, gossiping, and complaining). None of the nurses were described in terms of his/her strengths and weaknesses in interpersonal communication. In other words, none of the nurse educators were perceived to be "somewhat"

open or to be a receptive nurse "in some interactions." Dualism is a phase in intellectual development in which the individual believes that information is right or wrong, good or bad, and black or white facts (Del Collings, 2005; Weiler, 2004). Educational psychologist, Perri (1970) claimed that university students who are in the phase of dualistic thinking view educators as either good or bad authority figures, and the information that these educators provide is seen as correspondingly good or bad depending on whether they agree or disagree with the educator. In short, the majority of the participants viewed the nurses as either *good* or *bad* at interpersonal communication and the ways that these nurses communicated as correspondingly good or bad.

Dualistic thinking divides one's world into, not only opposites, but also into a hierarchy of inferior or superior which in turn creates conflict within the individual (Del Collins, 2005). In the present study, this conflict manifested in the participants' identification of nurses who were either *with them* (helped them learn) or who were *against them* (did not help them). Bauman (1991) argued that dualistic thinking originates from the desire to survive situations that are perceived to be chaotic or disordered; dualistic thinking is a means of dealing with ambiguity, obscurity, fuzziness, or ambivalence (pp. 6-7). Certainly, the participants had experienced substantial fear on NPR including: fear of the unknown, fear that they were not prepared, fear of harming the client, or fear of receiving a less than excellent grade. These fears arose from their perceptions of social situations and interactions with nurses and clients as obscure or fuzzy to them as inexperienced nursing students. In essence, they were trying to identify who could help them survive and thrive or transform into nurses on NPRs.

For individuals to transcend dualistic thinking (i.e.: to progress in their epistemological growth, according to Perri, 1970) and view their environment in terms of relationships and context-bound realities, they must be exposed to diversity, uncertainty, and instances when facts,

rules, and scripts cannot be followed (Weiler, 2004). Moreover, for a student to progress to Perri's next phase, multiplicity, in which the student can engage in critical thinking in *gray areas* between right and wrong (Perri, 1970), dispositional factors also need to be fostered within that student, including curiosity, open-mindedness, tolerance of ambiguity, conscientiousness, and fair-mindedness (Ku & Ho, 2010). While health care environments are resplendent with opportunities for exposure to diversity, uncertainty, and ambiguity, the participants necessitated further instruction and guidance in thinking within the gray areas of nursing practice and increased support in tolerating ambiguity and uncertainty. It is known that nursing students of the Millennial Generation often have limited tolerance for anxiety, ambiguity, and uncertainty due to their relative privilege and convenience of their lives compared to previous generations (Lower, 2008; Pardue & Morgan, 2008).

Participants were desperately afraid of that which they do not know and could not predict (which was revealed in their understandings of interpersonal communication). Dualistic thinking allowed them to gain a sense of perceived control over the unpredictable, yet it fostered the conflict among themselves and the nurses as evidenced by their dualistic perceptions of the nurses and nurses' interpersonal communication. Therefore, participants' experiences of the self as a nurse on NPRs commonly included judgment in the division of the nurses into two categories, those who would help them develop into nurses and those who would not. This dualistic thinking can be linked to the participants' level of development as novice nurses.

Nurses

Participants had experiences with nurses that prompted them to feel like they were becoming nurses and were part of a community of nurses. These interactions occurred at the *microsystem* within the relationships and interactions between nursing students and CEFs, and

nursing students and clients, as well as at the *mesosystem* level in the relationships between nursing students and BNs. Nurses whom the participants identified as helping them to experience becoming part of a community of nurses cultivated joy, growth, perspective, admiration, and compassion within the participants. Clinical Nurse Educators (CEFs) whom the participants claimed *built them up* demonstrated the "joy" (Lena) of an area of nursing practice. These nurses helped participants to recognize and reach their potential within the NPR, and to use their strengths as individuals. In these instances, the CEF-nursing student interpersonal communication was honest and open, and feedback was provided with a belief in the participant's potential such that "it just takes time" (Meredith) or "she saw the bigger picture" (Sophie). Moreover, nurses whom the participants had perceived as *positive role models* of communication connected with clients in ways that the participants had admired and wished to emulate in their own nursing practice and "feel the compassion" (June) of nursing. In these ways, nurses shared their passion for nursing with the participants by valuing them as individuals and valuing their role as nursing students.

CEFs whom the participants felt *built them up* had positive attitudes about nursing students and their contributions on the units. These CEFs built up nursing students by creating a community among the students on the rotation and getting the students to work as a team. Positive CEF-nursing student relationships were caring teaching and learning relationships that were created and sustained by positive interpersonal communication. Second, nurses whom the participants identified as *positive role models* of communication empowered them to connect with their clients by demonstrating how to listen to clients, respond to clients in ways that preserve their dignity, and use non-verbal communication.

Research supports this link between nursing students' development of positive professional identity and their positive experiences of relationship and interpersonal communication with nurses on the unit (Bradbury-Jones et al., 2011). Numerous studies have shown that nursing students who are welcomed onto a unit by nurses with respectful and accepting attitudes, have increased self-esteem (Chesser-Smyth, 2005; Melincavage, 2011), self-confidence to engage with health care providers (Callagan, 2011; Pedersen & Sivonen, 2012; Thorkildsen & Raholm, 2010), and self-worth as an emerging professional (James & Chapman, 2010). The findings of this study are congruent with this research.

A unique contribution of this study is in regards to the nurses' interpersonal communication recognizing participants' efforts on NPRs. Nurses in this study communicated both directly and indirectly to the participants that they were developing as novice nurses and part of a community of nurses. Indirectly, CEFs whom the participants perceived *built them up* "put trust in you" (Danielle) and gave them opportunities to use their talents and abilities. When students were given opportunities to use their skills, be responsible, and make a difference, they felt empowered (Bradbury-Jones et al., 2011). In relationships with Preceptors, the Preceptor gave participants increasing independence on the ward over time within a mentor-mentee relationship. For instance, in the theme, *Experiences of Resistance*, June's CEF had directly communicated her support for June to get a paliative patient up, and June was later recognized by her Buddy Nurse for her initiative on behalf of the client. Whether the nurses provided direct or indirect interpersonal communication recognizing the efforts and accomplishments of the participants, this acknowledgement allowed them to feel like capable nurses who were a part of the team on the unit. In short, they felt themselves to be transforming into nurses.

Unit Culture

Positive unit culture(s) gave nursing students an opportunity to belong on the unit. The participants' experiences of positive unit culture was system level of the *macrosystem*, the influence of the nursing practice culture and the ways that culture manifests on the beliefs of the nurses on the unit. A positive unit culture implied that nurses were supportive and compassionate with each other, the clients, and nursing students. As a result, participants felt safe learning in these contexts. Nursing research acknowledges nursing students' desire to "belong" in nursing practice environments (Bradbury-Jones, Sambrook, & Irvine, 2011; Cooper & Curzio, 2012; Cooper et al., 2009; Levett-Jones & Lathlean, 2008; Levett-Jones et al., 2007; Roberts, 2009). Fitting in is to belong and effectively be a nurse on the unit. Similarly, the present study has shown that positive unit cultures created environments in which participants felt like they were part of the unit and could participate in relationships among the nurses on the unit and learn.

Classmates

The unanticipated theme representing classmates' role in learning to become a professional nurse is *Classmates: Soldiers in white*. These friendships and collegial relationships occurred at the *microsystem* level and appeared to hold as much importance to the majority of participants as their relationships with clients and nurses. The significance of this theme was that participants' relationships with classmates created support, encouragement, advice, and empathy to the extent that these relationships were "the biggest component of nursing" (Danielle).

In learning to become nurses, the participants had similar experiences in their identical white nursing student uniforms. Their formative experience of nursing education created bonds between the participants and their classmates which were initiated and reinforced through supportive and encouraging interpersonal communication. The tone of the interviews with

several participants was that they could not have coped with the pressure of nursing education without these friendships. The uniqueness of the experience of learning to become a nurse on NPRs meant that, at times, only they could fully understand each other's needs. For example, Robert claimed that he had not maintained his friendships outside of nursing, "Make friends with nursing students around you...most other friends have fallen by the wayside...your friends what understand what you are talking about most of the time. And most of the things that we [nurses] talk about, just as a matter of course, is just not acceptable conversation. Just it's best if you don't try" (Robert). In other words, the intensity of the experience of learning to become a nurse meant it was challenging for Robert to relate to other non-nurses during his education.

Although a paucity of nursing literature exists on friendships between nurses, camaraderie and deep bonds are consistently reported. Harris, Ryan, and Belmont (1997) claim that friendship between nurses is deeply intimate, trusting, and enduring over the course of time. These bonds commonly begin in nursing school through shared memories of relying on each other. As practicing professionals, "nurses work under perilous circumstances" that lead them to "become vulnerable to each other which develops trust and intimacy" (Harris et al., 1997, p. 39). Likewise, Newland (2007) described the joys of nursing in the operating room and the "family like interactions" of the nurses (p. 22). Therefore, belonging to a caring profession has the potential to create strong bonds between nurses, and most participants in this study experienced these close friendships. Bonds between nurses have rarely been acknowledged in the nursing literature, and are, at least in part, hidden within the mounting literature on the existing of horizontal violence and bullying in the nursing profession, as the final overarching theme explores below.

Experiencing Disempowerment as Learners at Various Levels within the System

Participants experienced disempowerment as learners, a role stagnation, at the *microsystem* level in relationships with some CEFs, the *mesosystem* level in some relationships with BN and CL, the *macrosystem* level of the unit culture, the *chronosystem* level of the generation in relationships with older or more experienced nurses, and within themselves as learners. In this Theme, Habermas's view (that the formation of the identity of the nurse is communicative process of socialization grounded in reciprocal rational relationships of mutual understanding) is sanguine about role of power within subjectivation. Habermas's (1987) account of subjectivation implies that, as nursing students are socialized into the lifeworld of nurses, they internalize the social norms, relationships, and expectations of the lifeworld of nurses by arriving at mutual or shared understanding based on a consensus. Habermas argues that consensus occurs when actors (i.e.: nurses) engage in discourse, the better argument is accepted by both speakers (Thomassen, 2010). As Terri (1997) explains "in any discussion, therefore, all participants must employ the same level of language, refer to facts and knowledge with which all are familiar, contribute to the discussion in an open, honest way, and be prepared to place themselves in the position of others in order to understand the other's point of view" (p. 273). As this Theme reveals, the participants and nurse educators were commonly unable to meet each other in aforementioned rational consensus due to the power inherent in the relationships between nurses and novice nursing students, and the unequal ground upon which interpersonal communication occurred on NPRs.

Habermas (1987) explains conflict as arising from the system's colonization of the lifeworld wherein communication aimed at mutual understanding is substituted by a strategic orientation (Habermas, 1987). Essentially, the strategic action of the system (which is concerned

with the material reproduction of goods and services) is aimed at one actor getting another actor (or other actors) to do things as a means to an end. Stated more simply, nurse educators and nursing students may attempt to manipulate or influence each other when matters of the system take precedence, such as a nurse using a nursing student as an extra pair of hands to keep up with a demanding client load before the end of her shift so this nurse can keep her job. Habermas (1987) would likely agree that the nurse's behaviour is motivated by the pursuit of her own goals over the socialization of the nursing student to the lifeworld. In this final section of the Discussion, this Theme is rife with examples of nursing students' disempowerment because their role was not legitimized within the larger system.

In contrast to Habermas, French philosopher, Foucault (2003) understands subjectivation as a process of normalizing, disciplinary (strategic) power. Foucault (2003) does not believe in distinguishing between the lifeworld and the system because he argues that power-free discourse is impossible. The process of subjectivation is, for Foucault, a two-sided social process wherein, in this instance, both nurses and nursing students are subjected to power while simultaneously acting as subjects in this process (May, 2006). In this way, power and communication are intertwined such that nurses can support each other and use each other to achieve their own ends at the same time (Foucault, 2003). Roles, relationships, and statuses on the NPRs of the present study played a critical role in the subjectivation of nursing students, yet this theme demonstrates, the majority of participants failed to gain strategic knowledge for how to negotiate the power processes of the hierarchy of NPRs.

Critical Systems Theory (CST) was required to unpack the interpersonal communication and relationships in the hierarchical power structure of the NPRs. Over time on NPRs, participants were earning a new social status as a professional nurse. While the participants

understood the difference in power between themselves and the other nurses, they did not understand how to make this shift across this divide because few of them had professional experiences beyond the role of the student. This section discusses the ways that status and power played out through communication on NPRs with nurses, in negative unit cultures, with experienced nurses, and was re-enacted by the participants themselves at times.

Nurses

The interpersonal communication between nurses and nursing students was problematic because of the nature of the power relationships on NPRs. The nurses, especially the CEF and CL, occupied dual roles of (a) guiding and mentoring and (b) assessing nursing students. Therefore, relationships between nurses and students were bound in issues of power, authority, and status, no matter how helpful or kind the nurse. Nurses' interpersonal communication was rooted in such factors as years of experience, role within the unit, status in professional practice, or personal intentions toward students, yet participants interpreted nurses' discourse through the realities of being a nursing student which led to numerous misunderstandings about expectations of nursing students' on NPRs (or in the words of one student, "what they were supposed to be doing" [on the rotation].)

The participants' concerns about negative interpersonal communication directed towards them in their relationships with CEFs, BN, CL, and unit staff are representative of scholarly literature on nursing students' claims of bullying by nurses during their NPRs (Clark, 2008; Clarke, Kane, Rajacich, & Lafreniere, 2012; Cooper et al., 2011; Curtis, Bowen, & Reid, 2007; Levett-Jones & Lathlean, 2009; Myrick et al., 2006; Randle, 2003). Unlike the literature, participants did not use the term bullying but rather referred to nurses who were out to get them (Aubrey), picked at their faults (Jillian), picked on them (An), set them up for failure or blamed

them (Danielle), dominated (Sophie), hovered (Jillian, Robert), ignored them (June, Isabella), dismissed their concerns about grades or evaluation (June, Kathryn, Lena), and demonstrated an intolerance of nursing students (Aubrey, Isabella). Participants also described nurses whose interpersonal communication led to disloyal and distrustful interpersonal relationships between nurses (Meredith, Kathryn), complaining (Wren), manipulation (Kathryn), controlling behaviours (Isabella, June), and intimidation (Wren, Robert, Meredith). These findings are similar to the literature in which nursing students reportedly experienced: unrealistic expectations for performance, hostility, unfair criticism, threatening a poor evaluation, ignoring or excluding, attempts to belittle, humiliate, or demoralize, and purposefully withholding information (Clark et al., 2012; Curtis et al., 2007; Randle, 2003). This next section will discuss the themes of power and control linked specifically to CEFs, BNs, and CLs.

Clinical Education Facilitator (CEF). The CEF-nursing student relationship occurs at the systems level of the *microsystem* and significantly shapes the role of the nursing student. All participants in this study experienced nursing student status as a reflection of the inequitable relationship, often experienced as a power struggle, between the nursing students and the CEF. The participants' comments in Chapter Four demonstrate that disempowerment effects nursing students' intrinsic and extrinsic motivation as a developing nurse.

On the one hand, the theme *Clinical Education Facilitators: The Linchpin* establishes that the participants were aware of the power that the CEF held over them, for several participants described their ineffective attempts to communicate with their CEFs in order to negotiate and share power with regards to expectations, performance, or grades. The participants' abilities to communicate with their CEFs was a reflection of their status, for most participants felt that speaking up would threaten their ability to pass the rotation. These

experiences of powerlessness are similarly voiced in the nursing literature wherein nursing students claimed that they also could not confront CEFs because "We can't say much or we'll get kicked out for being disrespectful" (Cooper et al., 2011, p. 10) or "jeopardize our ability to successfully complete the program" (Myrick et al., 2006, p. 9). Thus, the participants in this study and nursing students in the academic literature were caught in a power struggle in which they felt their future careers as nurses were at stake if they attempted to confront nurse educators (Kolanko et al., 2006). In this way, the participants' communication was a reflection of their status and the limited power inherent in that status.

On the other hand, participants' perceptions of CEFs whom *we felt knocked us down* to the extent that they turned them on or off an area of nursing reveal that participants' expectations of NPRs were at times incongruent with the realities of learning to nurse in complex nursing practice settings. The participants had expectations of CEFs to be consistent teachers who provided highly structured learning with clear expectations, positive reinforcement, and feedback that led to A grades. They expected CEFs to know how to support nursing students who were struggling with nursing skills, interpersonal communication, EAL, a passive approach to learning, competitiveness among nursing students, and bridge theory and practice from the university to the ward. Participants anticipated CEFs who could help them fit in on the unit with the BN, staff nurses, and the unit culture despite the fact that many CEFs are also guests on the unit. Given many CEFs' lack of educational preparation for the role and the unpredictability of the health care environments of NPRs, these expectations were simply unrealistic and potentially unjust for the CEFs.

Therefore, I suspect that both nursing students and CEFs were learning to make affective shifts from different types or modes of being (Habermas, 1987). While students are learning the

role of the nursing student (and eventually, the nurse), CEFs are shifting from bedside nurse to teacher/nurse educator. A gap exists between what the nursing student is able to do and what the CEF is expecting the nursing student is to do. In the same way, a gap exists between what the CEF is able to do as a teacher and what the nursing students are expecting the CEF to do as a teacher. In these gaps, tensions develop between CEFs and nursing students which play out as a power struggle using interpersonal communication. As the CEF has significantly more power than the nursing student, the participants were not likely to have their expectations met. In fact within this tension, tremendous opportunity existed for the CEF to control, intimidate, dominate, or dismiss nursing students as a way of managing his or her inexperience as a teacher on NPRs.

Buddy Nurse (BN). In this study, the BN-student relationship existed at the systems level of the *mesosystem*, as the mesosystem implies that the BN's role includes relationships and responsibilities to several microsystems within which the nursing student participates. The themes also illustrate the participants' status relative to the BN, for the buddy system was disempowering to them as learners.

The two themes about the participants' interpersonal communication and relationships with BN demonstrate the participants' perceptions of BN who viewed nursing students in terms of their potential to be helpful in client care ("We don't know much", Jillian). Those participants who were not able to help the BN due to their inexperience perceived that the BNs related to them as if they were a hindrance, liability, a bother or burden ("We were 'little' nursing students", Isabella). As such, participants' status with the BN meant that many of the participants were unable to have relationships with BN on their initial NPRs. Scholars such as Curtis et al. (2007) have found that nursing students experience a pecking order in the clinical unit wherein staff nurses treated the nursing students and newly graduated nurses poorly. CST explains that

such interpersonal communication serves to teach nursing students the "culture of power" in which the BNs' knowledge, expertise, and experience is a form of power used to maintain the status quo among the nurses (Fisher-Lescano, 2012). In other words, nursing students must "serve their time in the trenches" as a "rite of passage" (Lena) to earn their way to the status of the BN, for "there are codes or rules for participating in power, and the rules of the culture of power are a reflection of the rules of the culture of those who have power" (Delpit, 1988, p. 327). In this view, the BN could have been exercising their power to maintain their status over the nursing student participants. Alternatively, BNs may have felt powerless at having nursing students assigned to them. BNs might have seen nursing students as another responsibility within an already demanding work environment. Even BNs who enjoy teaching or mentoring students could feel conflicted between protecting the patients and helping students to practice on patients.

However, another explanation for the BNs' reluctance to engage with the participants when they "didn't know much" (Jillian) was that BNs, like most CEFs, have limited (if any) educational preparation for their roles. In teaching and learning interactions with nursing students, BNs are prone to use the teaching and learning methods and strategies that are familiar to them. Stated another way, BNs are likely to teach using the methods and strategies that were used to teach them when they were in nursing school (Bonaduce, 2009). If the BN was educated and socialized as a nurse in a training hospital, he or she would have been extra workers/extra set of hands on the ward, not legitimized and supported as learners. In this case, present BNs have been teaching the participants the same way they were taught. Newly prepared nurses (who have low status on the unit) are often BNs, so the more experienced nurses can manage the more critical cases on the unit, for example. In this instance, the newly prepared BN is not only an inexperienced nurse but is also an inexperienced nurse educator. Essentially, I suspect that

participants and BNs had experienced a clash of expectations. Participants had expected to have an educator in the BN who would provide individualized, structured, and supportive opportunities to learn while the BN had expected the nursing students to be an extra set of hands on the unit. This clash in expectations did not foster interpersonal communication and relationships between the participants and BNs in several instances as evidenced by the themes about BN in this study. Nonetheless, CST reminds us that those in power within the established hierarchy have the advantage in such power struggles.

Course Leader (CL). In this study, the CL-student relationship existed at the systems level of the *mesosystem*, as the mesosystem implies that the CL's role includes relationships and responsibilities to several Microsystems within which the nursing student participates. The fundamental challenge in the interpersonal communication and relationship between participants and CLs was that CLs were responsible for supporting both the CEF and the nursing students. To support the CEF in his or her role as a teacher or nurse educator, the CL is responsible for responding to CEFs' questions about students or educational or unit processes; reviewing CEFs' student evaluations; writing Supportive Learning Contracts with a CEF when a CEF has determined that a student's performance puts this student at risk for failing the rotation; and acts as a faculty representative at the clinical site. The CL's role is significant in maintaining the requisite number of CEFs for the NPRs because the CL is the CEFs' source of support on the NPR. At the same time, the CL is the nurse educator that the students turn to when they have concerns their about the CEFs' teaching performance, expectations, grading, or behaviour. When problems or disagreement occur between a CEF and his or her student(s), the nursing students are often encouraged to approach the CL privately during the NPR or they may wait until the end of the NPR to express their concern in formal teaching evaluation of that CEF. In this study, half

of the participants explained that if a nursing student was passing the NPR the CL were *there but not there*, so these participants had limited interpersonal communication and relationship with CL. The role of the CL was that of an administrator.

In times of conflict such as passing or failing a nursing student on a rotation, the CL are inevitably forced to side with either the nursing student or the CEF. The CL may feel obligated to side with the CEF given the practical expertise of the CEF in this area of nursing, the difficulty of retaining CEFs in their roles in nursing education, and the work associated with training, monitoring, and evaluating the performance of CEFs. In instances when the CL did intervene in conflicts between the CEF and the nursing student in this study, Lena was reluctant to complain during the rotation, Isabella, An, Wren, June perceived that the CL was an "all mighty god" (Isabella) or gatekeeper who changed final grades or sided with the CEF in disputes with students, and Jillian's CL had used her status to remind nursing students of their place by mocking their errors on NPRs. Hence, the participants perceived CL as authorities who could not often be trusted.

Through the lens of CST, the CL, CEFs, and nursing students are "caught in self-reproducing relations of power" (Garnsey, 1993, p. 240) whereby the nursing student is learning, not only to acquire skills and knowledge, but also to be part of the hierarchy in nursing practice in which some inexperienced nurses (and inexperienced nurse educators, CEFs) are subservient to the more experienced nurses (and more experienced nurse educators, the CL). CST theorists explore the ways these coercive contexts are enacted and reproduced (Midgley, 2000). In this case, the conflicting loyalties of the CL to the nursing student and to the CEF, force the CL to exercise his/her power. To be perceived as supporting the nursing student over the CEF is to likely discourage the CEF to remain a nurse educator while to support the CEF over the nursing

student is to perpetuate the hierarchy of nursing students on the bottom rung, CEFs on the middle rung as they learn to be teachers, and CL on the top rung and in power.

Unit Culture

Participants were disempowered at the level of the *macrosystem,* the influence of the nursing practice culture and the ways that culture manifests on the beliefs of the nurses on the unit. CST is the lens for examining the ways in which nurses learn the systemic organizational culture of horizontal violence as students (Hutchinson, 2009; Johnson, 2009; Lewis, 2006; Randle, 2003). Any new member of a powerless group is at risk of experiencing bullying. As nursing students, the participants were especially vulnerable in the hierarchy because they are insecure in their roles and knowledge, and their collegial relationships are new (Sousa, 2012). The participants' feelings of being an outsider acted as a barrier to taking on the professional role of the nurse. A safe social learning context for learning, one that supported and legitimized the learning of nursing students, was not being created within negative unit cultures. In order to move into the professional role, nursing students need to feel that they belong.

In the unit cultures that the participants identified as negative, they felt excluded by the nurses because it was inappropriate for them to engage in negative interpersonal comments, behaviours, and attitudes of the unit as nursing students. As such, the participants were excluded from the lifeworld of the nurses on the unit through their inability to participate in the interpersonal communication on that unit (Habermas, 1987). Participants in the theme Nurses in Unit Cultures: Picking up the Vibe identified themselves as outsiders on these units, and they reportedly felt intimidated, awkward, and inferior to the nurses. The participants felt that in the role of the nursing student and with the status this role implied, it was not wise to resist, repress, or attempt to overcome a negative unit culture because they may risk failing the rotation. Several

participants expressed their desire to communicate differently (more kindly and more assertively) towards other nurses and nursing students when they became professional nurses.

The literature links negative experiences with nurses on the unit to negative identity development as a nurse. The participants' negative experiences learning how to fit in on a unit is known to impair nursing students' abilities to communicate effectively, particularly when they reported feeling: useless, inadequate, belittled, overwhelmed by the realities of the clinical context, like they were getting in the way, unaccepted by staff, ignored, disregarded or disrespected by nurses (Bradbury-Jones et al., 2011; Chesser-Smyth, 2005; Rush, McCracken, & Talley, 2009; Watkins, Roos, & Van der Wald, 2011). When nursing staff fail to show encouragement, interest, or respect for nursing students, but rather make "little attempt to hide their impatience and frustration," nursing students lack the confidence to communicate effectively with nurses and clients (Bradbury-Jones et al., 2011, p. 371; Chesser-Smyth, 2005; Chesser-Smyth & Long, 2013). In this sense, power was used by nurses to control nursing students rather than to motivate (Cooper et al., 2011). Notable CST theorist, Garnsey (1993) claims that "power has to do with the ways in which human energy is mobilized, combined, and channelled to achieve common ends, or dissipated, blocked or diverted through fractional conflict" (p. 240). On units with negative unit culture, the participants were privy to an imbalance and abuse of power (Lewis, 2006; Quine, 2001; Souza, 2012) that served to maintain the status quo of the nurses on the unit by excluding the nursing students.

In summary, the settings in which nursing students practice their first clinical skills, have their first encounters with patients and other health care professions, and attempt to establish their first collegial relationships are all too commonly environments that teach unequal power relationships.

Generation

The participants' experiences of interpersonal communication and relationship with older or mature nurses was largely at the systems level of the *chronosystem* which includes the historical moment in time that the nursing student was educated and socialized into the role of the nurse. CST is an important lens to consider the ways that nurses have been exploited within the Canadian health care system over time in terms of the impact of these realities on present day nurses and nursing education.

Several of the participants in this study had felt challenged by interactions and communication with "Old School" nurses because they had to be "respectful of their place on the bottom rung" (Wren) by showing respect and humility towards the older nurses. Robert, Isabella, and June perceived that older nurses were set in their routines or stuck in their ways. They saw these nurses as controlling or dominating. A recent phenomenological study (Foley, Myrick, & Yonge, 2012) on intergenerational conflict in nursing preceptorship found that different generations of nurses frequently hold contrasting perceptions of work environments. Most importantly, nursing students in Foley et al. (2012) claimed that they found interactions with older hospital trained nurses challenging because the older nurses tended to devalue their university education in nursing. In interviews with older nurse preceptors in the same study (Foley et al., 2012), the older nurses tended to diminish the value of nursing theory in favour of direct clinical practice experiences in nursing practice settings. The older nurses in both the present study and Foley et al. (2012) were most likely educated and socialized into the nursing profession in the hospital-based apprenticeship training model in which nurse educators emphasized the routine tasks of nursing care (Henderson et al., 2012). I suspect that many of the older or more mature nurses experienced by the participants were teaching and practicing how

they were taught. When I (in the role of an educator) have spoken to older nurses and ask them about their education, they are often nostalgic, describing their loyalty to their training school of nursing and pride in wearing its pin or crest. In these conversations, they have reminisced with me about nursing education as forming, not only their skills, but also their character or professional comportment through obedience to senior nurses. Moreover, experienced and more mature nurses have witnessed a decline in the deference to authority in the last two generations (Generation X and the Millennial Generation) (Lorentzon, 2003). In this way, CST shows that older nurses may wish to take their place as the senior nurses who teach novices as they were taught.

CST is useful for examining the professional and educational events that have reinforced the hierarchy in which nurses have limited power in health care. These experienced nurses have weathered (and survived) significant changes in the nursing profession. They have first-hand experiences and knowledge of changes in health care and in the working conditions of nurses including the unionization of nurses, cutbacks to health care spending or staffing cuts, nursing shortages, hallway medicine, strikes, and increasing technology in health care. Many nursing students are unaware of the extent to which nursing has evolved over time and generations (Alpers, Jarrell, & Wotring, 2011). Participants in this study may have devalued or been uninformed of the accomplishments of these nurses, so they only perceived them through the eyes of their generational and societal expectations (and communicated with older nurses as such). In contrast, learning about nursing history as part of undergraduate nursing education is known to develop a shared professional identity as nurses and provides a larger contextual perspective for present nursing (Madsen, 2008; McAllister, Madsen, Godden, Greenhill, & Reed, 2010) that may improve interpersonal communication across generations. Therefore, the gap in

understanding and interpersonal communication between older nurses and nursing students of the Millennial Generation may be bridged by instruction in the history of nursing.

Self

While many of these themes occurred in interactions between nurses and nursing students at the *microsystem* and *mesosytem* levels, CST theory is necessary to expose the hierarchical power structures as the chain of command which produces horizontal violence between nurses (Stevens et al., 2010b). Most of the participants identified their status as low or *on the bottom rung* relative to the other nurses which illustrates their sense of powerlessness. For example participants like Wren felt their interpersonal communication reflected their submissiveness or subservience to the other nurses in that they felt fearful of advocating for clients or being assertive. Similarly, in the theme *Being Thrown to the Wolves*, demonstrates participants' perceptions that they had to develop a 'thick skin' or 'a taste' for the challenges of the nursing role (stress, workload, standards of care, concern for clients); otherwise, they had to avoid interactions with nurses whom they saw challenging. How the participants *made sense of being thrown to the wolves* exhibits participants views of nurses as vulnerable in terms of their roles as teachers and nurses which led them to "eat their young" (Wren). Much has been studied about the horizontal violence occurs among nurses as members of an oppressed group who lack power within the hierarchy of the healthcare system (Farrell, 1997). As Wren and Lena argued, the principle claim is that nurses engage in conflict with each other as a means of releasing tension, pain, or frustration due to their inability to fight back (Farrell, 2001).

The participants had not anticipated that, in nursing, there would be such a need to learn to confront others. They experienced discomfort and distress in speaking up with nurses on NPRs and consistently perceived themselves to be ineffective or uncomfortable with conflict and

being assertive with nurses as evidenced by such reflections about themselves as “I am not used to being in conflict with anyone” (Meredith), “I have a hard time confronting” (Sophie), “I do not like conflict” (Kathryn), “I’m not good at being assertive” (Wren), “I still need to work on standing my ground” (Lena). Other participants (Danielle, Aubrey, Isabella, Robert) identified that nursing student classmates struggled with being assertive with nurses. Assertiveness among professional nurses has been defined as an interpersonal behaviour promoting equality, for the nurse who communicates assertively is respectfully expressing his/her rights, thoughts, and feelings (and those of others) within challenging hierarchical health care settings (Freeman & Adams, 1999; McCabe & Timmins, 2003). In fact, Evans (2001) has argued that, for nursing students to make the transition from student to professional nurse successfully, they must learn to be assertive.

Within this study, participants perceived that they were “not good at” conflict or confronting because they: lacked of experience with conflict (Sophie), lacked a natural aptitude or personality for confronting others (Danielle, Wren), feared offending others (Sophie) or failing the rotation (Danielle, Lena), lacked confidence (Meredith), or had feelings of being inferior, intimidated, or afraid of the nurses (An, Isabella, June, Meredith, Robert, Wren). Unfortunately, several participants dealt with conflicting interactions by: actively avoiding interactions with nurses (Aubrey, Kathryn, Robert, Wren) or hiding from particular nurses in linen closets, medication rooms, or washrooms (several participants claimed that their classmates hid from the nurses, but none of them admitted doing so themselves); crying (Isabella); or accepting/resigning themselves to criticism from a nurse even when they did not agree with this criticism (An, June, Lena). Hence, several of the participants dealt with conflict in ways that did not facilitate learning to be more assertive, but rather deepened the conflict.

In contrast, the findings indicated that three participants, Danielle, Meredith, and June, described negative experiences confronting their CEFs to explain their points of view regarding these nurses' expectations on the rotation. These participants' first confrontations reflect the findings of Begley and Glacken's (2004) study of Irish nursing students' assertiveness in which the authors found that "nursing students' perceived assertiveness skills developed as they progressed through their training [nursing education]" (p. 507). However, neither the Irish nursing students in Begley and Glacken's study nor the three participants in this study perceived that their improved assertiveness was the result of implicit teaching of assertiveness by nurses on the units. In both cases, the students' more assertive communication developed as "a defensive coping strategy" or "buffer" within some of the most challenging interactions with nurses and clients on NPRs (Begley & Glacken, 2004, p. 508). For example, Danielle had asked to speak to her CEF in private when she perceived the situation "was ridiculous" (Danielle). In other words, nursing students eventually asserted themselves as a means of surviving among the nurses on the unit.

Another concern that arises from the study findings on confrontation is how nursing students perceive assertiveness as a means of protecting or advocating for a client or fellow classmate. For instance, Kathryn initiated conflict with an LPN when she perceived that the LPN was too rough in feeding a client. Kathryn saw her own interpersonal communication in this interaction as assertive and told me that she liked to "even things out" for the underdog. Kathryn's interpersonal communication as she explained it to me lacked the respect for the LPN that is characteristic of assertiveness. Assertiveness is to communicate firmly and clearly, yet Kathryn had belittled the LPN in front of the client.

It has been established that assertive behaviour can be taught in nursing education programs through educational methods focusing on self-awareness and communication (Unal, 2012). The caveat however is that to teach assertiveness, nurses themselves must be effective models of assertion. Studies on the assertiveness of professional nurses, albeit somewhat dated at the time of this study, have shown that many nurses still lack assertiveness (Dunn & Sommer, 1997; Gerry, 1989; Kilkus, 1993; Poroch & McIntosh, 1995). This lack of assertion among nurses has been linked to the oppression within the nursing profession (Begley & Glacken, 2004). The literature on the oppression of nurses takes the view that nurses are oppressed because they are primarily female profession (Mansell, 2004; Torres, 1988) that is subordinate to physicians who rarely ask their opinions about client care (Bradbury-Jones et al., 2008; Busy & Gilchrist, 1992). The result of this oppression is horizontal violence among nurses (Farrell, 2001). Whether (or not) the participants' lack of assertion can be linked to oppression will be explored in the final sections of this chapter.

The participants in this study had entered nursing education with a desire to help and care for others, yet their status on NPRs opened their eyes to the realities of enacting caring within the larger system or hierarchy that may not structurally support nurses' ability to enact their knowledge base. Some participants were able to see the *paradox*, an essential tenent of CST that a profession so focused on caring for others has within its ranks interpersonal communication and relationships marked by violence. Therefore, recommendations for practice in Chapter Six, Recommendations for Practice are built on this discussion.

RESEARCH QUESTIONS

In many ways, I was naïve in formulating and asking the research questions because the answers were more complex than I had anticipated. Ultimately, the research went beyond the research questions. The principal research question was: Upon completion of Senior Practicum, what are the lived experiences and perceptions of nursing students' interpersonal communication during NPRs in two basic modalities: (a) with clients and (b) with nurses? This question was intended to identify the extent to which nursing student participants were aware of the roles and relationships in the context of NPRs and how such awareness shapes nursing students' interpersonal communication with clients and nurses. This phenomenon has been captured in the essence (van Manen, 1990) describing the participants' lived experiences of NPRs as fearful unsettling introductions to the various areas of nursing practice.

The research subquestions, namely: (1) What are nursing students' understandings and experiences of their interpersonal communication in nursing?; (2) What are the factors (both personal and contextual) that promote or hinder students' abilities to communicate effectively with nurses and clients on NPRs?; (3) how do nursing students define and describe the practice culture of nursing, and how do they make sense of interpersonal communication within that culture? are addressed below to the extent that the data and subsequent themes met my narrow perceptions of the phenomenon at the outset of this study.

The first research subquestion was answered to the extent that participants perceived their client and nurse interactions in light of their learning as nursing students rather than as novice nurse professionals. A dissonance existed between the idealized self as a nurse and situated self as a nursing student. Furthermore, participants appeared to lack awareness of this dissonance. Participants' understandings and experiences of interpersonal communication were a reflection

of their attempts to gain a greater sense of *perceived control* over their learning environments and to acquire the requisite interpersonal communication to interact with nurses and clients on NPRs. As a result, participants consistently believed that their role as nursing students was to determine how to pin down and pick up the "right" interpersonal communication to credibly enact the role of the nurse over time, and to ascertain who among the nurses would help them or hinder them in their learning process. This need to control and need to get it right is connected to their level of development and to their vulnerability as nursing students who experienced feeling powerless in this role.

In exploring the second research question, the personal factors that promoted or hindered nursing students' abilities to communicate effectively with nurses and clients on NPRs, I had initially thought the participants would reflect upon the myriad of ways that their personalities, personal capabilities, backgrounds, or attitudes contributed to the nursing profession and facilitated their interpersonal communication on NPRs. It was an unanticipated finding that the participants spoke of factors that they did *not* possess that *would have* facilitated their interpersonal communication with nurses and clients. To illustrate, nearly all of the participants claimed that they were "not good at" being assertive with nurses on NPRs. They claimed that standing up for themselves or for the integrity of classmates or clients in interactions with nurses on NPRs was challenging and distressing for them. These comments speak of the participants' lived experiences of powerlessness in interpersonal communication with nurses. In fact, this theme was most consistently identified among the personal factors that promoted or hindered the participants' interpersonal communication on NPRs.

With respect to other personal factors, less than a third of the participants had insight into the personal factors that *promoted* their interpersonal communication with nurses and clients

(such as taking initiative), yet more than half of the participants recognized and described the personal factors which *inhibited* their interpersonal communication (such as having limited prior experience communicating with the public and having English as an Additional Language). Therefore, the participants were well aware of what they perceived to be their deficits as communicators. The majority of the participants described themselves and their capacity in ways that showed they were hard on themselves (had high and potentially unrealistic self-expectation), yet expected A grades. For example, participants routinely expected to be able to communicate with clients and nurses without the requisite experience. This unrealistic self-expectation may have contributed to their role stagnation. At the time of the interviews, many participants had expected a great deal of themselves despite the fact that they had only just completed their nursing education.

The ways that individuals perceive they foster or hinder their own learning (in this case, the learning of interpersonal communication on NPRs) are the contextual factors. In this study, the contextual factors that the participants were aware of included the workload of nursing education, the importance of friendships among classmates, the impact of the unit culture, and, to some extent, the generation of the nurses on the unit. The contextual factors that the participants seemed to bear no knowledge or understanding of are linked to their status both as students and novices in the profession, the contextual factors at the exosystem level such as the changes in nursing education from diploma program in hospital to university degree or the power relations in health care, the systems in which nursing care is situated. While the more powerful roles of administrators, physicians, and the biomedical lens were beyond the scope of the systems used in this study, they warrant future study.

In research subquestion three, I had anticipated that the participants would report that their relationships, and their interpersonal communication with nurses and clients within those relationships, were profoundly impacted by the culture of the professional nurses. With the work of Habermas (1987, pps. 113-153) (who claimed that individuals are social beings who learn a role through the social exchanges of communication) in mind, I had assumed that the participants' interactions with nurses would generate mutual understandings between the nursing students and nurses such that cultural knowledge would be transmitted, thereby integrating the participants into the culture of nursing (Habermas, 1987). However, some participants were more aware of the impact of unit culture than others. Those like Meredith who were aware were clear and confident in their statements.

What I had not expected was that participants who recognized that unit culture impacted whether (or not) they could participate in the work and relationships of the unit as learners, saw culture as something that the nurses on the unit possessed. Participants perceived themselves as temporary visitors or guests on the unit, and as such, witnesses to professional nursing culture. They saw themselves as students rather than emerging members of the profession because they did not often feel safe taking risks or assert themselves as learners. Many were biding their time until they became professional nurses and then they promised themselves to communicate in more positive ways with nurses and nursing students. Despite completing ten NPRs as part of their nursing education at the time of the interviews for this study, many of the participants were still trying to find ways to fit in or belong in nursing culture(s). Hence, participants reported much less "solidarity" (Habermas, 1987, p. 137) among the nurses on their NPRs than I had expected. In fact, some participants were reticent about renewing the cultural knowledge they

experienced on NPRs while others saw themselves as agents of change with regard to negative culture.

Conclusions

The way in which a nursing student is treated during his or her clinical training shapes the kind of nurse this individual will become (Randle, 2003). The participants' communication with nurses and clients allowed them to establish normative relationships and achieve mutual understanding with nurses and clients when the participants were guided by nurses whom they perceived to welcome and include them into (the lifeworld) of nursing practice (role transformation). However, more frequently, the nurses' interpersonal communication lacked transparency for the participants, so the nursing students did not arrive at a mutual understanding of the novice nursing role. The participants retreated into the traditional university student role (role stagnation), or in instances of exercised power by the nurses, the participants experienced disempowerment (role oppression). The study research questions and the conceptual frameworks of EST and CST were used to examine the perceptions and lived experiences of 12 nursing students' interpersonal communication in terms of the ways that roles, relationships and statuses on NPRs shape students' interpersonal communication. While many of the challenges of learning to communicate on NPRs played out for the participants at the levels of the Microsystem with CEFs and the Mesosystem with BN or CL, many of the differences in expectations can be explained at the level of the Chronosystem (in terms of the moment in history) and many of the power struggles must be explored at the level of the Exosystem (in terms of changes in nursing education). CST was fundamental in examining how hierarchies among nurses are recreated through conflict in expectations among nursing students and nurses. In the final chapter of this dissertation, I will discuss the limitations of the study and make recommendation for practice. I

will consider how nursing students and nurse educators can improve their approaches to interpersonal communication on NPRs. Both nursing students and nurse educators need greater preparation for their roles on the NPRs of current nursing education. I make recommendations for nursing education in Chapter Six. The Themes, Holding on to the Traditional Student Role (role stagnation), Learning to Become a Nurse within a Community of Nurses (role transformation), and Experiencing Disempowerment as Learners (role disempowerment) are discussed and theorized on below in terms of the expectations of the nursing student participants and various nurses, as well as issues related to power and control on NPRs.

CHAPTER SIX: RECOMMENDATIONS FOR PRACTICE

In the end, I take responsibility for this research and the findings produced through my design and approach. Therefore, I wish to preface this chapter with the statement that these recommendations are based on the perceptions of nursing students who provided a range of responses. The fact that these recommendations are based upon the voices of students underscores the democratic thrust of education programming consisting of critical reflection at this moment in nursing education history.

Summary of Major Findings

Learning to communicate with nurses and clients is a significant part of the identity development of the nursing student during nursing education. More specifically, the technical and cultural knowledge of the nursing profession is transmitted and renewed in part through interpersonal communication. The identities of nursing students are formed into the social role of the novice nurse through interpersonal communication. This study examined the lived experiences and perceptions of nursing students' interpersonal communication during the Nursing Practice Rotation(NPR)s of an undergraduate nursing education program, specifically, in terms of the participants' communication in two different modalities: with clients and with nurses. I was interested in identifying the extent to which nursing students were aware of the roles and relationships on NPRs and how this awareness shaped their interpersonal communication with clients and nurses. Research sub-questions explored (a) the nursing students' understandings and experiences of interpersonal communication in nursing, (b) the personal and contextual factors that promoted or hindered their abilities to communicate effectively with clients and nurses during NPRs, and (c) the ways that nursing students defined and described the practice culture of nursing, including how they made sense of interpersonal communication within that culture.

Habermas's (1984, 1987) intersubjectivist approach was applied to discuss the formation of novice nurses as they attempted to use interpersonal communication to become part of the lifeworld of nurses. Although the participants had attempted to arrive at mutual understandings with nurses and clients about what it mean to be a nurse and renegotiate a new social role as a nurse, Habermas's notions of the transparency of communication in reaching consensus and colonization of the lifeworld by the system were insufficient in explaining the lived experiences of the participants' role stagnation and role oppression; the theory of French philosophers Derrida and Foucault were necessary to fully conceptualize two of the major Themes in this study.

This study required that thoughtful contemplation of the systems and layers of roles and relationships in nursing education, as well as a critical lens on the established power struggles of nursing and nursing education. Consequently, Bronfenbrenner's Ecological Systems Theory and Critical Systems Theory were complementary theoretical frameworks for the study. The specific hermeneutic phenomenological approach of van Manen (1990) was used because it is a practical and skillful methodology for investigating the lived experiences of individual to achieve an essence of the lived experience. As per phenomenology, the essence of the lived experience of the participants who are living (or have lived the phenomenon is the principle finding of the study. In this study, I explored the lived experiences of 12 nursing students who had communicated interpersonally with nurses and clients on Nursing Practice Rotations (NPR) as part of their undergraduate nursing education. This description of the phenomenon, its essence, is an interpretation based on the meanings of the data and the meanings of the researcher about the data (see Chapter Four for the Essence of the Findings).

The 12 participants' lived experiences of interpersonal communication with nurses and clients on nursing practice rotations can be synthesized around three Themes: (1) Holding on to

the Traditional Student Role (role stagnation), (2) Learning to Become a Professional Nurse within a Community of Nurses (role transformation), and (3) Experiencing Disempowerment as Learners (role oppression) within the ecosystem. These three Themes show that a nursing student's development into the nursing role was a non-linear process of struggling to find one's place within the relationships with nurses and clients on NPRs, as nursing students frequently received mixed messages of encouragement and disempowerment, and commonly held on to internal ideas about being a good student.

The Theme, Holding on to the Traditional Student Role (role stagnation) described the perceptions and expectations of novice nurses learning on NPRs. The fear and anxiety of novice nurses resulted in part, from of their perceptions that they had been left to fend for themselves in learning interpersonal communication with nurses and clients. Themes in the Findings chapter describe the participants' attempts to gain a greater sense of perceived control with interpersonal communication. Holding on represented the participants' continued theoretical orientation to interpersonal communication on NPRs. Stated another way, they wanted teachers on NPRs who helped them apply theory to practice, find professional boundaries with clients, interact with nurses, and achieve top grades in the process. Thus, this Holding On Theme is about differing expectations about roles on NPRs as linked to the nursing students' inexperience, the limited preparation and remuneration or recognition of CEFs, the workload of nursing education, and clinical practice realities in current health care.

The second Theme Learning to Become a Professional Nurse (role transformation) with a Community of Nurses summarizes the positive experiences of nursing students on NPRs that led them to perceive that they were becoming nurses and were part of a community of nurses. Interactions between nursing students and their CEFs, BN, CL, classmates, and in positive unit

cultures transformed their identify by building their confidence, cultivating joy for an area of nursing practice, demonstrating compassion for clients, and extending their perspective on their development into nurses. These nurses were seen as positive role models of interpersonal communication with clients and with other nurses on the unit. Moreover, positive unit cultures and supportive friendships with classmates created safe, trusting learning environments where nursing students could belong.

In the third Theme, Experiencing Disempowerment (as Learners) (role oppression), the participants' experiences of interpersonal communication with CEFs, BN, CL, negative unit cultures, older nurses, and their perceptions of themselves as powerless were unpacked using the critical lens of Critical Systems Theory (CST). CST was employed to examine the ways that power and status played out in interpersonal communication in ways that oppressed the nursing students' role shift to professional nurses. All participants in this study experienced nursing student status as a reflection of the inequitable relationship, a power struggle, between the nursing student and nurses. The nature of the power relationships on NPRs was problematic because nurses, particularly CEFs and CL, occupied the simultaneous roles of guiding and assessing nursing students. Therefore, a gap between what a nursing student could do and what a nursing student was expected to do created a tension which played out through interpersonal communication.

Interpersonal communication experienced by the participants led them to believe that some nurses were out to get them, pick on them, blame them, ignore or hover over them, dismiss their concerns, or make them serve their time in the trenches. Participants also described nurses whose interpersonal communication led to disloyal or distrustful relationships between nurses on negative unit cultures. Lastly, the majority of the participants felt that, even if they were willing

to risk speaking up, they were ill prepared to communicative assertively or confront others. Therefore, several participants assumed a subordinate role as a nursing student in which they tried to develop a thick skin, avoid conflict at all costs, cry, or accept criticism from nurses when they did not agree with this criticism.

Impact on the Researcher

Because the goal of phenomenology is to "reduce individual experiences within a phenomenon to a description of the universal essence" (van Manen, 1990, p. 177), I interpreted the participants' individual lived experiences and created a phenomenological description of what it meant for the participants to communicate interpersonally with nurses and clients on the NPRs of their nursing education. This universal essence of the participants is an interpretation of the phenomenon that mediated between the meanings of the data and the meanings of the researcher about the data (van Manen, 1990, p. 26).

In examining the systems and hierarchies in the data through the lenses of EST and CST, I realized the complexity of the roles, relationships, and statuses within nursing education. The ways in which the power intersects and clashes among different roles in the system is undeniable, yet I have a strong desire to avoid laying blame on nursing students, nurses, or the system of nursing education. Therefore, tensions exist between advocacy and science. Namely, how could the interpretation of this phenomenon mediate between the participants' meanings of their experience and my interpretations of those experiences? How could I advocate for nursing students and nurse educators yet conduct a rigorous study?

van Manen's fourth research activity and the Bradbury-Jones and Alcock (2011) Framework for Ethical Research Practice have been instrumental in achieving the requisite distance and objectivity to examine the research data. First, van Manen's fourth research activity, the art of

writing and rewriting, was the numerous drafts of the Findings and Discussion Chapters shared and debated over with the wise members of my Doctoral Dissertation Committee which created distance between the participants lived experiences and allowed me to "discover the essential structures of experience" (1990, p. 127). Essentially, my perceptions of the phenomenon have expanded, evolved, and matured through each new draft to the extent that, I increasingly saw the data for what it was: a phenomenon within the interconnected entirety of the experience. Stated more simply, the meanings of the essence of the phenomenon were found in rethinking, rewriting, editing, and polishing of each subsequent draft rather than in the emotional responses of the participants and the impact of these responses on me.

Furthermore, the Framework for Ethical Research Practice includes key questions for the researcher in terms of research contribution, research relationship, and research impact. These questions were invaluable in addressing the complexities of research with student nurses as a former nurse educator. I returned to these questions throughout the study as a means of ensuring ethical research practice. These concrete questions forced me to consider if I was too close to the participants' emotional experiences of the phenomenon rather than the focusing on a systems level consideration of the phenomenon. In essence, reviewing the framework from time to time reminded me of my role and my purpose in the research.

The research has contributed to my professional development as a nurse educator because I have a larger perspective on the system of nursing education. Presently, due to the evidence gathered in this study, these recommendations are those of the author who aims to improve the lived experiences of nursing students’ interpersonal communication with nurses and clients.

Recommendations for Nursing Education

1. Nursing Students

This study has identified the needs of nursing students in NPRs of undergraduate nursing education. First, students require explicit instruction to communicate with clients and nurses on NPRs. More specifically, they need practice tasks, assignments, and demonstrations both prior to and upon entering the nursing practice setting. Theory as it has been taught in the program seems to have proven insufficient in the application of communication knowledge in practice in this study. Therefore, instruction in interpersonal communication must be systematically integrated into nursing courses and NPRs.

Nursing students seem to require focused, open, critical, and practical discussions about the role and responsibilities of the nursing student in terms of taking initiative, setting boundaries, negotiating demanding clients or colleagues, and establishing therapeutic relationships with clients focused on clients' needs. These conversations should occur during post conference discussions at the end of each clinical day between the CEF and his or her group of nursing students. Faculty members from the university should participate in these discussions periodically and/or have communication with the faculty member in the corresponding course on campus, so theory can be linked to practice. Students in this study lacked insight at times into how their expectations and perceptions of clients can hinder their development as nurses. For example, clients are not someone to practice their new skills on but rather individuals with whom the cultivation of effective working relationships and partnerships in care is fundamental to nursing practice. Moreover, the participants were unsure of how to establish rapport with clients, respond to clients in crisis, or be assertive on behalf of clients, themselves, or other classmates.

Further, I recommend that participants' expectations of earning the best grade on the NPR be routinely challenged in order to transform them into practicing professionals. Trying to earn a top grade created communication based on competition, rivalry, and distrust among students and with the CEF in this study. In orientations to each NPR, nurse educators can emphasize the importance of client care as well as the roles and responsibilities of the nursing student, as well as the roles and responsibilities of the different nurses and nurse educators with whom nursing students will have interactions on NPRs. Friendships and peer support among nursing students positively impacted their experience of interpersonal communication with clients and nurses on NPRs. However, these friendships were so important because participants were attempting to cope in systems and layers of roles and relationships that were frequently unclear to them. The relationships provided them with orientation when otherwise disoriented.

2. Nurse Educators

Attention and resources need to be directed towards the development of nurse educators and further clarification of the differing roles and responsibilities of the nurse educators (CEFs and CL) and nurses (BN and staff nurses) who will engage in working relationships with nursing students on NPRs. For instance, the role of the CL was unclear to the participants, for CL were perceived as having divided loyalties between the CEFs and the students whom they mentored in teaching and learning respectively. The site leaders, experienced faculty who oversee all clinical courses at a particular practice site, were not mentioned by a single participant which seems to suggest that the participants were unaware of this role in nursing education. The roles and responsibilities of the BN also appeared to the students to be, at times, at cross-purposes with their learning: some participants were used as an extra set of hands in client care rather than

taught the role of the nurse, alternatively, some participants perceived that if they were unable to help with care, their impression was that they should get out of the way of the BN.

Further, analysis of the participants' lived experiences point to a perceived lack of clear useful ongoing feedback for the interpersonal communication by nursing students on NPRs. Consequently, I recommend that CEFs participate in training in how to give clear procedural instructions, provide useful feedback, and lead supportive discussions about client care and communication with students. The role and relationships inherent in the CEF means being involved, engaged, and present for the students in ways that may, at times, mimic the kinds of teaching that students experience at the university. For example, CEFs can provide step-by-step instructions or assign specific exercises or specific tasks for the students to complete during the clinical day. Because, current one-day workshops for CEFs are insufficient and poorly attended at the university, online modules can be developed through learning development systems within modern universities with reinforcement through face-to-face classes. This approach would standardize the education of CEFs and create a cohort of CEFs who could support each other in learning to improve their teaching.

The roles and responsibilities of the Buddy Nurses require further clarification. The faculty of nursing should provide this guidance to BN in the form of workshops and written documentation of the aims of the NPR (in the form of a syllabus or set of instructions from the faculty) on the unit. I recommend that BNs be provided training through semi-annual paid workshops offered by university nurse educators in the practice setting about sharing their thinking, decision-making, and clinical reasoning with nursing students in the practice setting. For the students to learn, student observation of BNs and attempts to replicate the communication of a favoured BN are insufficient because the student often did not understand

why the BN made the decisions he or she did. For instance, BNs can explain why they set the boundaries they do with clients, or explore the context of their choices in terms of workload or policies and procedures of the unit. BNs can also encourage students by sharing their passion for nursing and communicating a positive attitude towards nursing students and their learning. BNs require paid training, potentially by the CL, about how to communicate their thinking processes to nursing students as well as to reinforce the importance of helping nursing students to learn in the practice setting.

I recommend that the role and responsibilities of the CL be made more transparent to both the nursing students and CEFs. The CL offers tremendous potential for bridging the theory-practice gap for nursing students. In this vein, the CL can educate the BN about theory courses on campus that correspond to the immediate rotation and promote the nurse educator role among unit managers or other staff on NPRs. The faculty of nursing guide for NPR nursing education should more clearly outline the roles and responsibilities of the nursing student, CEF, BN, and CL, and engage in conversations with nurse educators in these roles to keep these role descriptions relevant to the practice of nursing education.

3. Nursing Education

Based on the perceptions of the nursing students in this study, I recommend that greater links between the theory courses on campus and the realities of the practice settings be created because entrance to practice is a confusing shock for students who quickly identify the disparities between the abstract ideas of theory and the concrete realities of practice. These linkages can occur by CEFs and university nursing faculty engaging in curricular and course planning together. CEFs must be paid for any curricular and course planning time. If CEFs and university nurse educators set priorities for the nursing students' education together, the content saturation

rampant in current nursing education can be minimized. Similarly, nurse educators who teach theory courses should be allocated time in their work allotment to travel to the NPR sites once per month to participate with the CEFs, BN, and nursing students on NPRs. Greater links between theory and practice can be created only if both university and practice settings make an effort to bridge the gap for students and raise the status of CEFs' contributions in the process through scheduled dialogues between practicing nurses and faculty.

Furthermore, I recommend that the nursing student role be legitimized and supported in the practice settings of NPRs, for negative experiences with nurses in practice impair students' abilities to communicate effectively. Ideally, nursing students should be welcomed on to units and given opportunities to belong. If the unit culture does not support this attitude towards nursing students, professional development from CL or administrators in the undergraduate nursing education program can be implemented with regards to the importance of guiding and mentoring the students who will become future colleagues in nursing practice. Nursing education will also necessitate a greater systems knowledge of the nursing profession in terms of its history, fiscal realities, and professional identity within healthcare. This strategic systems knowledge should be provided in greater detail at the university to prepare nursing students to practice. University nurse educators who re-immerse themselves in the practice of nursing, in the form of one day a month on NPRs with their students for instance, will create opportunities to link theory and practice in meaningful ways for students.

Limitations of the Study

The limitation of the present study is the relatively small sample size despite the fact that data saturation was achieved. I was surprised by the sheer volume of information from the interviews with the participants which with my field notes was hundreds of pages from which to decipher meaning; I had not anticipated that when I posed these questions to the participants,

they would have so much to say. It is possible that the participants came forward to engage in the interviews because they felt they had especially positive or negative stories to tell about their NPRs. However, it was impossible to obtain access to a list of students completing their Senior Practicum, the final NPR, at the time of the time of recruitment; therefore, I had to rely upon the Centre for Nursing and Health Research to send emails to potential participants.

Overall, the findings in this study indicate the need for a study with a much larger sample across different nursing education programs. This study considered the experiences and perspectives of 12 nursing students in one nursing education program, so it is difficult to generalize about the lived experiences of all nursing students. Further, future studies investigating these same research questions from the point of view of the nurses, clients, or nurse managers would be invaluable to our understanding of this phenomenon, particularly in the professional development of nurse educators.

Concluding Thoughts

When reflecting on the communication about opposing fleets during the First World War, Winston Churchill (1931) wrote that "Out of intense complexities, intense simplicities emerge" (p. 623). I understand this statement to mean that once we come to understand complex systems or problems, the answers and possible solutions present themselves. The tremendous time and effort taken to understand the complexity of the context or situation is as important as the offered solutions. Certainly, one of the most important outcomes of this study is that the numerous quotes, thoughts, and perspectives provided by the participants were heard and contemplated upon. Through publications, I hope to further disseminate their words and ideas. Their lived experiences are important and meaningful. While the solutions are in few ways simple, the intention to make change in nursing education after reading this work is clear.

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Appendix A: Letter of Invitation

UNIVERSITY OF MANITOBA | Faculty of Education

This letter is being sent by the Manitoba Centre for Nursing and Health Research (MCNHR) on behalf of Cosette Taylor, a doctoral candidate in the Faculty of Education

Once you have completed Senior Practicum, I would like to invite you to participate in my study. As part of my doctoral studies in Education, I am interesting in doing research to learn more about the ways that nursing students learn to communicate with clients and nurses on the various units and within communities during the clinical part of nursing education. More specifically, *the purpose of this study is to examine the perceptions and lived experiences of nursing students' interpersonal communication with clients and nurses.*

The Faculty of Nursing at the University of Manitoba has agreed that the MCNHR can send this email to you, and this research has been approved by the Education/Nursing Research Ethics Board. If you have any concerns or complaints about the project, you may contact the Human Ethics Coordinator (HEC) at 204-474-7122 or email: Margaret.bowman@umanitoba.ca

As a participant, you would have an opportunity to speak confidentially with me about what it's been like for you to communicate with clients, nurse educators, and other nurses, such as: CEFs, Buddy Nurses, Preceptors, and unit nurses during your clinical practice rotations. Information you share will help other nursing students or nurse educators in the future by advancing knowledge about interpersonal communication of nursing students on nursing practice rotations.

Because Dr. Wanda Chernomas is a member of my dissertation committee, students who have been advised by Dr. Chernomas on Senior Practicum are not eligible to participate in this study.

To learn more about this study, please contact cosette.taylor@umanitoba.ca**.**
Thank you for your time and consideration

Cosette Taylor

Appendix B: Reply to Participant's Expression of Interest

Once the potential participant contacts me, I will send the following email response to the potential participant:

Thank you for your interest in the study "The Lived Experiences and Perceptions of Nursing Students' Interpersonal Communication in Nursing Practice Rotations." I would like to arrange to meet you at a time and location that is convenient for you, such as your home, a meeting room at library or hospital/care facility, for instance. Before we can begin discussing your experiences and perceptions, I will review the Consent Form with you for the study which includes a clear explanation of the roles of the investigator and the participant in this study.

Please reply with dates and times that would work best for you. I look forward to hearing from you.

Cosette Taylor

Investigator

Appendix C: Letter of Consent

UNIVERSITY OF MANITOBA | Faculty of Education

Dear Nursing Student,

This consent form, a copy of which you will receive for your records and reference, is part of the process of informed consent. This form should give you a clear idea of what the research study is about and what your participation will involve. If you would like more details about any of the information stated here or information that is not found here, you should feel free to ask before participating or at any point during your participation in the study. Please take the time to read this information carefully.

I am inviting you to participate in my study. As a participant, you will have an opportunity to speak confidentially with me about what it's been like for you to communicate with clients, nurse educators, and other nurses, such as: CEFs, Buddy Nurses, Preceptors, and unit nurses during your clinical practice rotations. The role of the participant is to share information in an interview with the researcher, Cosette Taylor who, in this case, will record that information, create a transcript from which to draw conclusions about information from all the participants. Information you share will help other nursing students or nurse educators in the future by advancing knowledge about interpersonal communication of nursing students on nursing practice rotations through a publication or talk by the researcher (Cosette Taylor).

As part of my doctoral studies in education, I am interesting in doing research to learn more about the ways that nursing students learn to communicate with clients and nurses on the various units and within communities during the clinical part of nursing education. More specifically, *the purpose of this study is to examine the perceptions and lived experiences of nursing students' interpersonal communication with clients and nurses.* The Faculty of Nursing at the University of Manitoba is aware of this research project.

Your participation in the research study includes *one* 45-90 minute research interview with myself, Cosette Taylor at a mutually agreed upon time and location. I will ask you questions about your experiences and perceptions of yourself as a nurse, your communication with clients, nurse educators, and nurses including: CEFs, Course Leaders, Site Leaders, Buddy Nurses, Preceptors, or staff nurses. The interview will be audiotaped and transcribed within four days of the interview; I will be the transcriber. A copy of the transcript will be given to you for your review. You may add, modify, or delete any portion of the transcript by email, and will have two weeks (14 days) to make these changes.

I will use the information that you and the other participants provide me (in the form of transcripts) to write a description that summarizes nursing student participants' experiences and perceptions of their interpersonal communication with clients and nurses on nursing practice rotations in this study. Then, I will email you a copy of this description to you and the other participants and ask each of you to individually confirm if the description represents your experience in communicating with clients and nurses in clinical, and if not, how it might better reflect your ideas about their interpersonal communication in nursing practice rotations.

When all participants have approved the description by email, it will form the basis of the results section for my PhD dissertation in Education. From this dissertation, I will use this information to publish journal articles on the same topics.

You face minimal risk in participating in this study. As a participant, you will be asked to describe personal experiences of nursing practice rotations, including potential conflict that you may have seen or experienced yourself. Therefore, you may potentially feel sadness, frustration, or confusion as you describe these experiences. If within the context of a research interview, your description of your experiences of interpersonal communication in Senior Practicum **or** other nursing practice rotations leads you to feel upset or distressed, the interview will stop, and I will ask you if you wish to continue. I will refer you to appropriate counselling resources if I am concerned about you in any way.

The information collected during the research interview will be kept confidential. Every possible precaution will be taken to disguise your identity so that anyone who reads the research findings will be unable to connect you with this study. You will be assigned a pseudonym, and any quotes from your transcript will be disguised so that you cannot be identified. Your gender, Senior Practicum site, and clients' conditions will be deleted from the transcripts; I am not collecting data on sites, nor am I interested in data on client conditions. I will also change the names of your CEFs, Course Leaders, Site Leaders, CEFs, Buddy Nurses, Preceptors, clients, and classmates to pseudonyms so they cannot be identified.

Only my Professor, Dr. Nathalie Piquemal will have access to the transcripts, and the transcripts will have any personal identity information removed. The audiotape and transcript will be stored in my office in a locked cabinet, separate from the consent forms. I will shred the audiotape and transcript of our conversation by December 31st, 2017.

Your signature on this form indicates that you have understood the information regarding your participation in this research study and agree to participate. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions form their legal and professional responsibilities. You are free to withdraw from the study at any time by contacting Cosette Taylor or Nathalie Piquemal by email, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the the Education/Nursing Research Ethics Board. If you have any concerns or complaints about the project, you may contact the Human Ethics Coordinator (HEC) at 204-474-7122 or email: Margaret.bowman@umanitoba.ca
A copy of this consent form has been given to you to keep for your records and reference.

You are free to withdraw from this research study at any time by contacting myself or my advisor by email, and/or refrain from answering any questions you prefer to omit without prejudice or consequences with this doctoral student or the University of Manitoba.

Cosette Taylor, Investigator
If you have any questions about the project, you may contact me at:
474-6353 or cosette_taylor@umanitoba.ca

Thank you for your time and thoughtful consideration.

Participant's Signature and Date

Researcher's Signature and Date

If you wish to receive any publications that come out of my research with you, please mark "yes" or "no" and provide your preferred contact information.

___ yes ___ no

_____ preferred contact information

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Appendix D: Interview Guide

Thank you for agreeing to participate in this study. I value your ideas and opinions about your experiences as a nursing student.

First, I'd like to ask a few questions to learn a bit about you:

- What prompted you to choose nursing as a career? What area(s) of nursing practice interest you in your career? Why? What draws you to these areas of nursing?
- How do you see yourself as a nurse? What kinds of characteristics or abilities are important to you as a nurse?
- How would you describe your communication style in your personal life with friends and family? A part-time job? How would you describe the way you communicate in clinical practice or Senior Practicum with nurse educators and clients?
- What have your experiences of clinical practice rotations and Senior practicum been like? What experiences have been most memorable to you?

Next I'd like to ask you about some of your experiences in clinical practice and Senior practicum, which we'll refer to as "clinical" as so many students do:

- **Microsystem**: What were your experiences with your clients like? What did you find challenging and what did you find rewarding about these interactions? In your experience, what is the role of the CEF? What were your relationships with your CEFs like? How did your relationships with your CEFs shape your experience of clinical practice? Can you give me some examples?
- **Mesosystem:** What was the role of the Preceptor or Buddy Nurse in clinical?? What was the role of the Course Leader? How did these nurses shape your clinical experiences? Can you give me an example of a memorable nurse who communicated effectively with clients? What did you learn from this nurse?
- **Exosystem**: To what extent were the assignments in clinical helpful in learning to communicate with clients and other nurses?
- **Macrosystem**: As you complete your nursing education, what are your impressions of the nursing practice? What does being a nurse mean to you now compared to what it

mean to you when you started your nursing education? What were the most important lessons in your nursing education that you feel prepared you to be a nurse?

- **Chronosystem**: Based on your experiences in clinical, what makes you feel excited or fearful about a career in nursing? What kinds of challenges and opportunities do you and your classmates face compared to older more experienced generation of nurses? What advice would you have for a new nursing student?
- **Critical Systems Theory:** The interview questions intended to elicit this information from the participants are: As a nursing student in clinical, did you witness or experience any conflict? Among whom? How did nurses communicate in such situations? How did you react to conflict? How did this conflict impact or influence your ability to communicate with clients or other nurses? The interview questions intended to open discussion on these topics are: How have nurses supported or nurtured your development into a nurse? To what extent have nurses helped you learned to communicate situations involving conflict?

Appendix E: Framework for Ethical Research Practice

A	Research Contribution	B	Research Relationship	C	Research Impact
1	Do participants understand the purpose of the study?	1	Do the participants understand the relationship that they are entering into?	1	Will participants face risks that they would not have to face otherwise?
2	Do participants know that they are contributing to a project to gather generalizable knowledge to help others in the future?	2	Are the participants aware of how the relationship with the researcher will differ from the relationship that they have with her as an educator?	2	Do participants understand the potential risks of taking part in the research?
3	How much information do participants need to understand the nature of the research?	3	What are the potential role conflicts?	3	What benefits might participants gain from taking part in the research?
4	Are participants likely to be confused by the information provided to them?	4	What strategies are required to manage potential role conflict?	4	How can any emotional effects on participants be managed?
5	Are participants able to understand the language used in communication with them?	5	What measures are in place to protect the participant confidentiality and in what situations might this need to be overridden?	5	What ongoing mechanisms are required to support/help participants if necessary?
6	What mechanisms are required to ensure that potential participants can ask questions about the research?	6	What potential is there for abuse of researcher power?	6	Have all potential participants been provided with an equal opportunity to participate in the research?
7	What external pressures might impact the fair treatment of participants?	7	What mechanisms are in place to minimize the negative influence of researcher power?		
		8	How easy will it be for potential participants to decline to take part in the study?		
		9	What mechanisms are in place to facilitate participants' withdrawal from the study if they wish?		

Bradbury-Jones & Alcock, 2010