THE LIVED EXPERIENCE OF NURSE EDUCATORS:

CARING EXPERIENCES WITH STUDENTS

IN CLINICAL TEACHING

by

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THE LIVED EXPERIENCE OF NURSE EDUCATORS: CARING EXPERIENCES WITH STUDENTS IN CLINICAL TEACHING

BY

MARTA JAYNE CRAWFORD

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

ABSTRACT

Proponents of a paradigm change in nursing education focus on the need to transform student-teacher relationships from the traditional teacher role marked by authority and power to one characterized by reciprocity and caring. Although caring has been cited by many authors as the essence of nursing and the core value of nursing education, the concept of caring in nursing education has remained largely unexamined and undefined. If caring is to be a core value in nursing education, nurse educators have little guidance as to how this caring teacher-student relationship would be manifested and developed. This research study used Heideggerian phenomenology to explore the paradigm case exemplars of nine experienced clinical nurse educators with regard to caring in baccalaureate nursing clinical education. The research method included a pre-interview, a paradigm interview, and a final interview to clarify perceptions of the paradigm interview and to share the emerging categories with the participant. Hermeneutic analysis was achieved through data analysis according to the steps identified by Collaizi (1978). The study identified the motivation to care for students as arising from the conceptualization of caring as a human trait and caring as a moral imperative. The selection of strategies of caring reflected conceptualizations of caring as an affect and an interpersonal interaction. Caring as a therapeutic intervention was expressed in a number of complex strategies. Uncaring was identified as shielding students from unpleasant realities and taking over client care from students.

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CHAPTER ONE

INTRODUCTION

Although caring has been cited by many authors as the essence of nursing and the core value of nurse educator-student relationships, the concept of caring has remained largely unexamined and undefined in relation to nursing education (Bevis, 1989; Diekelmann, 1990; Tanner, 1990). Only one study was located which specifically explored caring in the teacher-student relationships in baccalaureate nursing education (Miller & Haber, 1992). If caring is to be a core value in nursing education, nurse educators have little guidance as to how this caring relationship could be manifested and developed.

Caring in teacher-student relationships has been proposed as essential to nursing education for two principle reasons:

1) in order for nurses to implement caring practices, it is necessary that they experience caring in their lives and in their educational environment (Brown, 1991; Diekelmann, 1990; Green-Hernandez, 1991; Keen, 1991; Miller, 1991; Sheston, 1991; Watson, 1990). Hegyvary (1990) states that, although nursing students enter nursing with caring

ideals, they are subjected to negativism about nursing as a profession, and as an educational experience. Hegyvary suggests that in the absence of a caring and supportive climate of education and practice, it is difficult for students to learn to care. Increasingly, nurse educators are identifying nursing students who have been wounded by life events which have occurred prior to their enrolment in nursing education. Some nursing students have experienced a lack of caring in their lives. The variables affecting how these students learn to care for patients have not been studied.

2) The current behaviourist paradigm in nursing education has resulted in teacher-student relationships which focus on evaluation of student performance to the impairment of learning. The proliferation of behavioural objectives has created the necessity of teachers focusing on what is measurable, and observable, to the detriment of educative learning (Diekelmann, 1990; Paterson, 1991). Aspects of nursing that are difficult to observe and measure, such as caring, are typically not evaluated. The focus on performance outcomes which are measurable and observable has lead to teachers priorizing evaluation over teaching/learning (Paterson, 1991), and students learning to please the teacher in order to survive in the program (Diekelmann, 1990). This approach has assumed that students are the product of the educational system, focusing on what

the teacher does or does not do as determinants of what the student learns. It has denied the role of the student and the role of the interactional quality of teaching and learning (Dinham, 1988).

This research project is designed to identify how caring is manifested in the relationships between nursing students and experienced clinical teachers.

Problem Statement

My personal reflections on clinical teaching led to the following research question: What is the lived experience of experienced nurse educators with regard to caring for students in clinical education?

This question is addressed in the following subquestions:

1) What is the nature of clinical teachers' experiences with caring within the teacher-student relationship?

2) What are the perceptions of clinical teachers regarding caring within the teacher-student relationship?

3) What are the internal and external variables which influence the teacher's perspective of caring for students?

4) How do teachers perceive their role in regard to caring for students?

5) How do clinical teachers express caring within the teacher-student relationship?

Definition of Terms

Definitions of terms used in this report are as follows:

Clinical teaching: teaching that occurs in the proximity of a patient in individual or group practice setting.

Clinical teacher: a teacher in a basic nursing program who is assigned to teach students in a specific clinical practice setting.

Experienced clinical teacher: a clinical teacher who has at least five years of clinical teaching experience and one year of experience clinical teaching in a basic baccalaureate nursing program.

Student: an individual enrolled in a basic baccalaureate nursing education program.

Assumptions

The assumptions which underlie the study are the following:

1) The caring of clinical teachers for nursing students has an effect on how nursing students learn to care as nurses.

2) The perspectives of clinical teachers about caring for nursing students is shaped, in part, by their experiences with nursing students.

Philosophical Perspective

The philosophical perspective used to guide the research is Heideggerian phenomenology. This form of phenomenology seeks to "make visible the nature and meaning of being (Rather, 1992, p. 48), focusing attention on the study of experience as it is lived. Although Boyd (1988) acknowledges that phenomenology is interpreted in a number of ways, she identifies and describes five central concepts of phenomenology which provide a framework which is descriptive of the nature of being human, a distinguishing feature of phenomenology. These concepts are: embodied consciousness, experience, perceptions, modes of awareness and expression.

Definition of Concepts

Embodied Consciousness: The individual's body is described as the natural access to the world, in which consciousness is expressed in a particular approach to the world (Boyd, 1988, p. 69). Embodied consciousness encompasses the perspective of human reality, biography, past experience, knowledge of the world, and social facets of the world (Boyd, 1988, p. 69).

Experience: lived experience is the focus of phenomenology. Experience is not what we think, but what we live through.

Perceptions: perception is described as the "original act of consciousness" and refers to the awareness of the

appearances of things (Boyd, 1988, p. 69). Perception provides access to experience of the world. The knowledge embedded in the "everyday" experience can be made visible and known through exploration of the perceptions of the individuals living that experience (Rather, 1988, p. 48). In phenomenology, the perceived world is a totality open to an infinite variety of perspectives, presenting us with "evidence of the world not as it is thought, but as it is lived" (Boyd, 1988, p. 69).

Modes of Awareness: Scientific awareness is one possible mode for interpreting experience (Boyd, 1988, p. 70). Awareness is based on experience and perception, and enables the construction of meaning in our lives and our world (Boyd, 1988, p. 70).

Expression: Research, art, and humour are described by Boyd (1988, p. 70) as significant expressions of awareness. Expressions are the outcomes of our ways of making sense of our existence.

Phenomenology as the Guide to The Research Design

This research is guided by the philosophical perspective of Heideggerian Phenomenology in both data collection and data analysis. The premise that one's experiences in the world and reflections on that experience constitute knowledge (Boyd,1988) provides direction to the research design. Accordingly, paradigm interviews are

appropriate. Paradigm analysis is based on the premises of narrative inquiry. Narrative inquiry is viewed as the construction and reconstruction of personal and social stories (Connelly, & Clandinin, 1990). Diekelmann (1990) describes narratives as empowering to nurse educators since they reveal expertise as teachers, the how of nursing education, and the practice knowledge embedded in the common understandings of teaching. Nurse educators possess individual experiences of what it is to care for nursing students. These individual experiences can be brought to the level of perception by enabling the nurse educators to reflect upon their experiences, and to tell their stories (Boykin & Schoenhofer, 1991; Benner, 1984; Connelly & Clandinin, 1990; Diekelmann, 1990; Krysl, 1991; Sandelowski, 1991).

The method is based on the phenomenological assumptions that knowledge about the world is constructed on human experiences, multiple realities are possible, and experience becomes known to us only after reflection (Boyd, 1988). Krysl (1991) quotes a Nunamiut definition of a story-teller that parallels the phenomenological perspective on story telling, an informal form of paradigm research: "The story teller is the person who creates the atmosphere in which wisdom reveals itself." Experienced clinical teachers were chosen as the study population because these teachers possess a wide range of experience as clinical teachers, and

are likely to yield a variety of perspectives about the caring relationship of students and teachers. The experiences of nurse educators, once captured at the level of perceptions, can then be expressed to the researcher, who uses the four basic strategies of phenomenological research (bracketing, analysing, intuiting and describing) to interpret their modes of awareness (Swanson-Kauffman & Schonwald, 1988). The relationship of the philosophical perspective to the research questions and design is summarized in Appendix A.

Organization of the Thesis

This chapter has provided an introduction to the study, describing the need and purpose of the study. Chapter Two provides an overview of research and issues pertaining to educator-student relationships in nursing education. Chapter Three outlines the research design, methods, sample population and ethical considerations related to the research. The potential sources of reactivity in the study are also addressed in this chapter. Chapter Four will describe the clinical teachers' perspectives on caring for students in clinical education and the variables that affect their perspectives. Chapter Five discusses the implications of the research findings for the development of clinical teachers and for further study. Chapter Six summarizes the research study.

CHAPTER TWO

REVIEW OF THE LITERATURE

Some controversy exists in relation to conducting an initial review of the literature in phenomenological research. Although a "purist" approach advocates that the researcher approach the subject with complete naivete (Omery,1983), this stance is regarded as lacking in pragmatism, and at odds with reality, by other phenomenological researchers (e.g. Benner, 1992; Rather, 1992; Riemen, 1986; Swanson-Kauffman & Schonwald, 1988). In the purist view a review of the literature results in the need for the researcher to "bracket out", or set aside, more information in the data collection phase of research. This additional information is then viewed as possibly contributing to researcher bias.

However, other phenomenological researchers (e.g. Benner, 1992; Rather, 1992; Riemen, 1986; Swanson-Kauffman & Schonwald, 1988) have chosen to conduct a review of the literature. These authors acknowledge the practical advantages of providing a review of the literature to ethical review boards and funding agencies. Sandelowski, Davis, and Harris (1989) further elucidate the

appropriateness of a review of the literature in a phenomenological study by casting doubt on the concept of complete naivete of the researcher in selecting a research topic or question. They contend that the researcher does not enter the project without prior knowledge and beliefs which influence the researcher's perception of the subject of inquiry. Therefore the literature review serves to help the researcher to identify, or bracket, their pre-existing perceptions and beliefs (Sandelowski, et al., 1989).

The literature review in this report identifies two studies which explicitly explore teacher-student caring relationships in nursing clinical education. The review is expanded to include the following criteria for inclusion:

1) theoretical and anecdotal literature exploring teacher-student relationships in nursing education

2) research exploring perceptions of clinical education in Nursing by teachers and students

3) research in nurse-patient caring relationships which identify differences in perceptions of nurses and patients. Although not specific to nursing education, this research sheds light on caring as it is exemplified in the Nursing profession. Nursing educators have as their basis for caring that which is specific to the discipline of Nursing (Diekelmann, 1990).

The literature review is organized according to the philosophical perspective of phenomenology described by Boyd

(1988). The five central concepts of this framework include embodied consciousness, experience, perceptions, modes of awareness, and expression. Modes of awareness and expression are concepts which will be specifically addressed in Chapter Three. The concepts of embodied consciousness, experience and perceptions will form the framework for this review of the literature.

Embodied Consciousness

Boyd (1988) describes embodied consciousness as "simultaneous contact with the world and with oneself" (page 68). In this view of knowing reality is holistic, and is determined by the social-political aspects of the world, knowledge of the world, and one's past experience (Boyd, 1988, page 29). The professional perspective of each nurse is influenced by nursing's history. The social and political antecedents that shape nursing education constitute a shared embodied consciousness. This first section of the literature review will examine this shared history in nursing.

Social-political antecedents

The majority of nurses share similarities in social-economic status and gender. This shared biography has had profound and poorly examined effects on the definition of, valuing of, and research into caring in the profession of nursing (Baines, 1991; Gordon, 1991; Miller, 1991; Symmonds,

1990; Sheston, 1991; Tanner, 1990; Watson, 1990).

Baines (1991) contends that female dominated professions, such as nursing, are undervalued and under-rewarded in our society. Historically, women moved into the paid labour force by taking on roles which were "natural extensions" of their roles as female care-givers in the home and community (Baines, 1991). Nursing, education, and social work developed as female professions which could not claim the prestige and status of male dominated professions such as medicine, law, and engineering (Baines, 1991, p. 36). A consequence of the lack of appreciation for women's ways of knowing, women's work, and women's roles, is the tendency of women to also believe that the work they do is of little value; and the modelling of the female dominated professions after the models of patriarchal male professions (Baines, 1991; Daniels, 1987; Finkelstein, 1989).

Spengler (1976) states that the socialization of women and of nurses takes place in a political arena in which the minor role assigned to nurses is reflective of that assigned to North American women as a whole. The socialization of nurses has been to a passive role (Spengler, 1976; Holloway & Penson, 1987). This role has not prepared them to be social activists or to debate the importance of caring in the health care setting (Spengler, 1976).

The valuing of caring in nursing and in nursing education is constrained by its association with women and

nursing, and its distance from the reigning patriarchy (Roberts, 1990; Watson 1990). In the wider society the caring work of nurses is viewed as a "natural attribute" and as such is not valued or rewarded (Baines, 1991; Ray, 1987; Shead, 1991). The acts of caring in our society are described as invisible by feminist writers (Watson, 1990; Miller, 1991). Miller (1991) states that, because females in general are invisible in our society, the care they give is unseen and therefore unappreciated by the dominant groups of society. Caring theory acknowledges and values the traditional values of both women and nursing (Gaut, 1991; Green-Hernandez, 1991).

Knowledge of the world

Much research has explored the unique world views of women in North American society. This body of research provides a perspective on the development of the self-perceptions of women. Belenky, Clinchy, Goldberger, and Tarule (1988) in their qualitative study of Women's Ways of Knowing, distinguish between the traditional male model of knowing and the experiences of women in North American society. Women are more likely than men to be "received knowers", envisioning the development of knowledge as arising from others and not from themselves (Belenky, 1988). The tendency in our society, for both men and women, is to judge the differences between men and women as evidence of women's inferiority (Beck,1990). This interpretation of the

past experience of women, and consequently of nurses, illuminates the difficulty Nursing confronts in developing respect and credibility for the merit of caring in our society.

Eyres, Loustau, and Ersek (1992) used the theory of Belenky et al.(1988) to study the ways of knowing of twenty-one first year baccalaureate nursing students. This phenomenological study replicated the semi-structured interviews and data analysis methods used by Belenky et al.(1988), in a non-longitudinal study. Although they did not classify any "silent" knowers (authority seen as all-powerful; without a voice) in their sample, each participant demonstrated traces of the multiple positions of knowing described in the original research. Younger students in the Eyres, et al. (1992) study were predominantly "received knowers" (learn by being told; always one right answer); older students predominantly subjective knowers (value own voice and experience; still one right answer). Minority women in their sample were more likely to assume the received knower stance. The researchers suggest that this finding is reflective of some cultures in which the questioning of authority is considered to be inappropriate. The analysis of the male students' transcripts did not fit the typology from Women's Ways of Knowing, and instead conforms with Perry's (1970) typology of relativism. This research lends further support to the notion that men and

women in North American society are socialized differently, see the world through different lenses, and approach the world from different viewpoints.

Past Experiences

The embodied consciousness of Nursing is shaped, in part, by the traditions of nursing education. Traditionally nursing education has embraced a behaviourist paradigm in the education of students into the profession of Nursing (Bevis, 1990; Paterson & Larsen, 1991; Tanner, 1990). This model of clinical education has required clinical teachers to focus on objective, measurable student behaviours and the determination of a student's clinical competence by direct supervision (Diekelmann, 1991; Paterson, 1991; Stanko, 1981). The focus on what is measurable has contributed to nurse-educators priorizing evaluation over teaching; and objective performance over caring and learning (Bevis, 1990; Tanner, 1990; Paterson, 1991; Stanko 1981).

The outcomes of the behaviourist paradigm are students who value "pleasing the teacher" (Diekelmann, 1991); experience difficulty generating knowledge from their clinical experience (Lindeman, 1989); and demonstrate limited ability to make clinical decisions (Tanner, 1989). The outcomes of these tendencies on the abilities of nursing students to generate knowledge and produce change in the health care system has not been tested.

The emphasis on the power structure of the evaluator-

student relationship has repressed the recognition of the caring aspects of clinical teaching. A paradigm shift from the behaviourist focus on evaluation of student performance to an educative focus on student learning would change the nature of teacher-student relationships from the "teacher as evaluator" to the "teacher as a co-explorer of meaning and significance" (Diekelmann, 1990).

A major tenet of the reconceptualists in nursing education is that in order for nursing students to learn and practice nursing in a caring manner, they require a learning environment that values and fosters caring. The student-teacher relationship must be transformed from the evaluative focus, described by Diekelmann (1990) as "adversarialism in action", to a basis of caring (Brown,1991; Green-Hernandez, 1991; Keen, 1991; Miller, 1991; Watson, 1990).

The studies reviewed in this section support the contention that women and men in our society are socialized in different ways. This qualitative research has illuminated some of these differences in ways of knowing. Phenomenological studies have revealed the effects of constant evaluation on nursing students. There is a paucity of research examining the effects of the embodied consciousness of nurses on the outcomes of Nursing and nursing education. Anecdotal and opinion commentaries raise poignant questions about what might be if nursing students were socialized in a different model of clinical education.

It is apparent that the relationships of nurse educators and nursing students have been constrained, with a narrow perspective based on the power and authority of the teacher.

Experience

Heideggerian phenomenology examines the everyday experience of being (Rather, 1992), with the understanding that the everyday experience of being human is obscured when it is seen as ordinary and not subjected to reflective analysis. Boyd (1990) defines lived experience as human involvement in a situation before interpretation of the experience. In order to investigate the implications of caring in clinical education, it is necessary to first examine what is known about the culture of nursing clinical education.

Researchers such as Diekelmann (1990); Hughes (1992); Miller and Haber (1992); Nelms (1990); Paterson (1991); Stanko (1981); and Windsor, (1985) have shed light on the lived experiences of nursing students and nurse educators. Rich descriptions of the data in their research reports form the basis for the interpretation of the perceptions of students and nurse educators.

Diekelmann (1990) studied the lived experiences of generic undergraduate and returning registered nurse students, and their educators through hermeneutic inquiry. A major theme illuminated by this research is "learning as

evaluation." Students described the pervasiveness of being evaluated, preparing for, and coping with evaluation. Teachers reported enormous amounts of time devoted to "grading care plans, writing anecdotal notes, writing test items, and grading papers" (Diekelmann, 1990, p. 26). This focus on evaluation seems to arise from the perception of the teacher as "gatekeeper" to the profession, requiring that the teacher remain the final authority and holder of power (Diekelmann, 1990; Paterson, 1991).

Diekelmann (1990) raises some pertinent directions for further research:

1) the need to examine the assumption that if learning has not occurred if it has not been evaluated

2) to make excellence in teaching visible

3) to find ways to reconcile these struggles with students and to empower them in the curriculum and

4) to explore new ways of being as teachers.

Nelms (1990) conducted interviews with 17 senior baccalaureate students. These students characterize the experience of being a nursing student as: a life-pervasive intense commitment; centred on the meaningful aspects of clinical education; shaped by real experiences with patients; and that the core of learning is one-to-one interactions with their clinical teachers. Consistent with other researchers' findings (e.g., Hsieh & Knowles, 1990; Windsor, 1985), the participants of the study cited peers as

the most reliable source of support in their learning process.

Windsor (1985) employed a naturalistic inquiry method to study nursing students' perceptions of clinical experience. Nine senior baccalaureate students were interviewed twice. Students expected clinical teachers to have high expectations of them, to ask "good" questions, to explain their expectations, and to provide honest feedback. The study proposes a tentative framework for the understanding of a developmental process in nursing education. The developmental process reflects a gradual change from relative dependency on, to increasing independence from, the clinical teacher. Although the students affirmed that relationships with peers, staff, teachers, and patients were important to learning, only peers were deemed to be consistently supportive to them. The importance of the clinical teacher in their learning experience is reflected by the fact that 30% of the students' comments centred on the clinical teachers. It was important to the students that the teacher "care about me as an individual" (Windsor, 1985).

Hsieh and Knowles (1990) explored the role of two teachers in facilitating the preceptor relationship between 18 senior diploma nursing students and their registered nurse preceptors. This study classifies seven themes of importance in the teacher's role: trust; clearly defined

expectations; support systems; honest communications; encouragement; and mutual sharing of self and experience (Hsieh & Knowles, 1990).

Paterson (1991) in a one year ethnographic study of six clinical teachers explored the phenomenon of caring in clinical teaching. The participants in her research were a convenience sample drawn from both diploma and university nursing programs. The research explored the caring behaviours of the teachers in their interactions with students using participant observation to identify teacher behaviours. The researcher validated the observations through interviews and concept mapping with the teachers.

Paterson indicates that the teachers in her study displayed caring for most of their students. In order to care for their students the teachers in Paterson study stated that they had to "get to know" the student in a personal way. Teachers used the strategies of: attentive listening, "being there", demonstrating respect for students, accepting the students, and being supportive. The teachers indicated that caring for the students, by getting to know them, allowed the teachers to design "meaningful learning experiences", and to consider the student's unique situation in responding to learning or performance difficulties.

Paterson's research describes caring, as well uncaring, behaviours of clinical teachers. Professional

caring is described by Green-Hernandez (1991) as being unique; different from intuitive caring. Professional caring is perceived by this author as an intentional act, mastered by means of formal education and experiential learning (Green-Hernandez, 1991). Extrapolations from this definition of professional caring lead to a questioning of the nature of the responses of teachers when students in Paterson's study developed major clinical performance problems. The clinical teachers in the study at times lacked the knowledge to respond appropriately to student difficulties such as learned helplessness. They failed to take action when students' clinical difficulties were attributable to problems in curriculum design. The teachers viewed themselves as powerless to control the spontaneous and highly unpredictable events of clinical practice (Paterson, 1991). These behaviours of the teachers are not congruent with the definition of professional caring. The examination of uncaring by clinical teachers in Paterson's study revealed variables (e.g., expectations for student's success) which determined the clinical teachers' willingness and ability to demonstrate caring in their relationships with students. It is, therefore, important to include uncaring, as well as caring, in an exploration of teacher-student relationships.

Uncaring, in Paterson's research, is portrayed in the crystallization model she developed from her research. In

this model, when teachers formulated negative opinions of students and judged that the students were unlikely to succeed in the clinical rotation, a predictable series of events occurred. Following crystallization each example of the students' performance was judged to support the prediction that the student would fail. Whereas other students were viewed as being potentially successful, these students were not. The efforts of the teacher became directed towards proving that the student had failed. The withdrawal of teacher helping behaviours occurred (Paterson, 1991).

Hughes (1992) used a structured interview method with ten baccalaureate nursing students to examine their perceptions of the climate for caring and the faculty behaviours through which students experience caring. The students in this study described a climate for caring as one in which faculty: acknowledge and respond to student stress and anxiety; provide students with opportunities to express their opinions and concerns without fear of reprisal; and place high priority on meeting students' needs (Hughes, 1992). The subjects described teacher-student interactions characterized by modelling, dialogue, practice, confirmation, and affirmation as producing a climate within which caring is experienced. Students were empowered by teachers who used effective role modelling; anticipated both the student's and the patient's needs; and focused primarily

on nursing role expectations rather than student role expectations (Hughes, 1992).

The influence of nursing faculty experiences of caring in their work environments was explored in a phenomenological study by Grigsby and Megel (1992). Interviews of seven nursing faculty members defined caring as connectedness with patients, faculty colleagues, and administrators. Caring in the work environment was positively associated with the faculty's ability to facilitate the development of caring in their students (Grigsby & Megel, 1992).

It appears from the research conducted by Hughes (1992), Paterson (1991), and Grigsby and Megel (1992), that nurse educators care for students in a manner similar to nurses' caring for patients. This finding is congruent with Diekelmann's (1990) assertion that nurse educators teach out of their practice as nurses. If teachers care for students from their perspective of caring for patients, some of the same issues identified in the nurse-patient caring literature will apply to nurse educator-student caring. For example, Benner (1984) identifies that knowing the patient is critical to the nurse patient relationship. This is similar to the finding of Paterson (1991) that knowing the student is paramount in determining teaching strategies in clinical teaching. Pagana (1988) further identifies that for the nursing student, not knowing the teacher contributes

to their sense of fear in clinical practice.

The research investigating the lived experiences of nurse educators and nursing students is beginning to provide a more holistic view of the processes of nursing education. Although the reconceptualists in nursing education call for the centrality of caring in educator-student relationships, there is a paucity of research which focuses on this issue. Because the locations of the research studies were varied, their consistent findings lend support to the contention that these experiences are not unique to one faculty or country.

Perceptions

Boyd (1988) describes perceptions as an act of consciousness or awareness of the appearance of things (p. 69). The perceived world is described as a totality open to an infinite variety of perspectives. This section of the review of the literature will present research which examines:

1) student anxieties experienced in nursing clinical education

2) mutual and dissonant expectations of nursing students and clinical nurse educators

3) nurse-educator and nursing students perceptions of the meaning of caring for clients, and

4) pertinent research in nurse-client perceptions of caring.

Anxiety

Anxiety is a conspicuous and pervasive feature of clinical education in studies of nursing students' perceptions. Numerous studies which have examined student and teacher perceptions of their clinical experience are summarized in Appendix B. In a study of medical students Eysenck (1979) identifies that although moderate levels of anxiety may be beneficial in a learning situation, high levels of anxiety have a negative affect on achievement. This section of the literature review examines the pervasiveness of anxiety in clinical eduction and the factors mediating nursing students' anxiety in clinical education.

Pagana (1988) studied 262 baccalaureate students from seven universities to evaluate degrees of threat (potential for harm) and challenge (potential for mastery). The survey questionnaire demonstrated that students were generally more challenged than threatened ($p=0.001$). Higher stress levels were positively correlated with feelings of inadequacy. Content analysis of the open-ended part of the questionnaire classifies six major threats experienced by these students: personal inadequacy (77.1%), fear of making errors (34%), uncertainty (28.6%), the clinical instructor (26%), a feeling of being scared (19.5%), and fear of failure (14.1%)

(Pagana, 1988). The pervasiveness of students' fears of personal inadequacy supports both Infante's (1985) and Lindeman's (1989) assertions that it is often forgotten that the nursing student is not a nurse, but is learning to be a nurse.

Pagana (1990) explored factors mediating perceptions of threat in a study of 261 baccalaureate students. She determined that social support scores were not related to threat scores. The researcher postulates that the usual support network of students is not effective in buffering the unique stressors of clinical education. Windsor (1985), in a naturalistic inquiry method, found that peers are viewed as a source of essential emotional support and that teachers and staff nurses were desired sources of support. The implication of these findings is that teachers, staff nurses, and student peers should be studied and cultivated as sources of support for students in clinical education.

This research strongly indicates that nursing students have many anxieties and fears in clinical practice. These fears arise from the "teacher as evaluator" model of clinical teaching. Students' greatest anxieties are fear of failure and of making mistakes (Davidzar 1985; Nelms, 1990; Pagana, 1988; Windsor, 1987).

Lewis, Gadd and O'Conner (1987) used a quasi-experimental design to investigate the effect of time delay on the anxiety level of ninety baccalaureate nursing

students between orientation and first clinical day. Anxiety levels were significantly higher for the group that waited six days from orientation to first clinical day. The Spring groups had a higher anxiety level than the Fall semester groups. Although the study failed to distinguish a significant difference in information recall on the time delay variable, this difference could be attributed to the students knowing that a quiz on the orientation material would be conducted.

Quasi-experimental questionnaire designs were used in the research of Bergman (1990); Davidzar (1985); Dufault (1985); Flagler, Loper-Powers and Spitzer (1988); Olson (1983); Mogan (1987); Lewis (1987); and Pagana (1988; 1990). These studies shed light on nursing clinical education from the perspectives of nurse educators and nursing students. For example, Flagler, et al. (1988) proposed that the retention of students in Nursing is related to their self-confidence as a nurse and is essential to clinical competency. Questionnaires were given to 155 baccalaureate nursing students. Students rated the clinical instructor behaviours of giving positive reinforcement, showing confidence in the student, encouraging and accepting questions, providing support, and giving specific feedback as beneficial to their self-confidence (Flagler, et al., 1988). Instructor behaviours which most hindered student self-confidence were no feedback or negative feedback only,

intimidation, and distress about students' lack of knowledge or performance. These findings are consistent with those of Kormorita (1966). Dufault (1985) studied 32 experimental and 32 control subjects to measure the effect of a future oriented nursing course on the locus of control of 64 registered nurses in a baccalaureate program. The results of the study suggest that the locus of control of students can become more internal as the result of the course. A limitation of the study includes the lack of control over the wide number of variables (e.g., influence of peers) inherent in a three credit course. Dufault acknowledges that the nature of the course encouraged dialogue between the instructors and the students, and that this interaction, rather than the content, may account for at least some of the change scores. The recognition of the value of nurse educator-student dialogue is congruent with the findings of Flagler et al. (1988), Hughes (1992), and Nelms (1990).

Fear of a negative evaluation causes many students to avoid meaningful interactions with teachers (Paterson, 1991; Stanko 1981) and limits the experiential learning which is the goal of clinical education. Many researchers recommend a change in the teacher role from that of primarily the evaluator of student performance to a role of support (Diekelmann, 1991; Flagler, 1988; Hughes, 1992; Pagana, 1990; Paterson, 1991; Mogan and Knox, 1987; Nelms, 1990; Windsor, 1987)

Mutual Expectations

Several studies have investigated the mutual expectations of nurse educators and nursing students (Bergman, 1990; Davidzar, 1985; Flagler, 1988, Olson, 1983, Mogan, 1987; Paterson, 1991; Stanko,1981). This body of research illustrates both congruence and dissonance in the expectations teachers have of students and that students have of teachers. The dissonance of perspectives contributes to the anxieties of students in clinical education and thus detracts from the learning which should be occurring in clinical education.

Mogan and Knox (1987) studied 28 university teachers and 173 baccalaureate students to identify the "best" and "worst" characteristics of nursing faculty. The questionnaire used in this study was developed in their earlier research. The findings reflect a dissonance between student and faculty perceptions. The students valued most the interpersonal skills of the teachers; teachers placed most emphasis on their teaching skills. Bergman (1990), in a study of 134 baccalaureate students and 23 faculty members, reports a similar emphasis of teachers on "competence" and students on rapport with faculty.

Studies of nursing students' perceptions of factors influencing their success were conducted by Davidhizar and McBride (1985) and Olson (1983). Students in Davidhizar and McBride's study tended to attribute failure to external

causes, while success was attributed to internal causes. Olson's study demonstrates that students perceive that their application of theory to clinical practice is facilitated by individualization, verbalization, warm-up, and closure sessions. These studies indicate that students' expectations of teachers may not be any clearer to teachers than are teachers' expectations to students. Both studies support the need for individualized and caring relationships between students and teachers.

Perceptions of caring for clients

Several studies pertaining to the perceptions of caring in nurse-patient relationships were explored. A summary of studies in caring in nursing can be found in Appendix C. Two major findings from nurse-patient caring research are relevant to the exploration of teacher-student caring:

a) The variance in the priorization of caring behaviours between nurses and patients indicates a need to explore caring from the perspective of all involved in the caring relationship; i.e., both nurse educators and students (Chipman, 1991; Kormorita, 1991; Mangold, 1991; Riemen, 1986).

b) Riemen (1987) reports differences in the perceptions of males and females as to what constitutes caring. The majority of nurse educators and nursing students are females, and there is a need to explore the perceptions of males.

Kormorita, Doehring and Hirchert (1991) investigated 72 nurse educator and 38 nurse manager and practitioners' perceptions of caring for clients. Consistent with previous research in nurse-patient caring (e.g., Brown, 1982; Cronin, 1984), these researchers report that nurse educators share the profession's focus on comfort and trusting relationships with patients.

Mangold (1991) used a questionnaire with 30 senior baccalaureate nursing students and 30 nurses to measure their perceptions of effective caring behaviour. The nurses' and students' perceptions of most and least important behaviours were consistent with previous research. Nurses in the study tended to place a higher value on the development of a trust relationship with the client than did nursing students.

Studies exploring perceptions of nursing clinical education reveal the pervasiveness of student anxiety. This anxiety arises from the "learning by evaluation" aftermath of the behaviourist paradigm. The priorization of evaluation over teaching and learning has produced a rift in the relationships of nursing students and nurse educators. The relationships of nursing students and nursing teachers are at times characterized by a dissonance in mutual expectations. Nursing students require a unique support system to manage the experiences of clinical education. While peers are recognized as reliable sources of support,

the role of the teacher as a source of support is highly valued by students. While dialogue between nursing students and nurse educators is valued by nursing students and declared to be essential to the transformation of nursing education, there is a scarcity of research examining the nature and effects of this dialogue.

Nurses, nurse educators, nursing students and clients have differing perceptions of caring. Male and female patients describe caring in dissimilar ways. There is a need to explore caring from a variety of perspectives.

Summary of the Review of the Literature

There is a paucity of research investigating caring in nursing education. Much of the literature is anecdotal in nature, based on definitions derived from nurse-patient caring literature. Many questions concerning the nature of caring by teachers and students remain unanswered.

The conclusion that anxiety is a prominent feature of nursing clinical education is well supported by research. The behaviourist paradigm has been instrumental in shaping the practices of nursing clinical education such that evaluation is prized over learning, and objective performance over caring. This emphasis on what is easily measurable has lead to undervaluing the importance of caring, and has, according to the literature, disrupted the relationships of nurse educators and nursing students.

Diekelmann claims that the relationships between nurse educators and nursing students are in need of healing (Diekelmann, 1990). Nurse educator-student relationships must be transformed from adversarialism, to a stance of co-explorers of meaning (Diekelmann,1990).

There is much to be investigated regarding the role of caring in nursing clinical education. Although caring is proclaimed to be the central tenet of the reconceptualists of nursing education, there is a paucity of research examining this concept. For example, what are the effects of various caring strategies in the teaching of caring to students? Do students recognize caring behaviours of teachers as caring? When do the caring behaviours of teachers enable students to learn caring and when do the teacher behaviours have detrimental effects on the students? Is caring in nursing education reciprocal (i.e., the student also cares for the teacher)?

Many problems in nursing education have been attributed to the behaviourist paradigm. It has resulted in students focusing on pleasing the teacher rather than on learning. Teachers have focused on what is easily quantified and measured, denying the importance of the interactional quality of clinical teaching (Paterson, 1991). There is a scarcity of research examining the influence of any alternative model of clinical education on the relationships of nursing students and nurse educators.

The question of how to enable nurse educators to care for nursing students is unanswered. How important is the work environment of teachers to their ability to care for students? What are the effects of teacher self-care on students learning to care for themselves as nurses? How pivotal is the skill of self-care in the development and retention of nurses? What are the boundaries of caring in the teacher-student relationship and how do nurse educators learn these boundaries?

We do know that nursing students desire support from their teachers. Nursing students are asking for teacher-student relationships characterized by one-to-one interactions, dialogue, and "getting to know" each other. Diekelmann (1990) bids us to re-examine nursing clinical education. Her call to make excellence in teaching visible suggests that the exploration of the practices of excellent clinical teachers may help to identify ways to reconcile the past "struggles" with students, and to explore new ways of being as teachers (Diekelmann, 1990).

CHAPTER THREE

THE RESEARCH DESIGN

Hermeneutic phenomenology was selected as the research design for this study because the perspectives of nursing clinical educators with regard to caring in teacher-student relationships has not been adequately studied. The study design is guided by four strategies of phenomenological research: bracketing, intuiting, analysing and describing. Each of these strategies will be explained as it relates to the design.

A pilot study was conducted with a colleague prior to finalizing this research design. This pilot study was valuable in refining the aims and techniques of each of the three interviews. Previous experience in the technical skills of tape-recording and transcribing has been useful, both in preparing for the study interviews, and in planning the time frame of the study. This chapter will present the data collection and data analysis plan of the study.

Data Collection

Method

Data was collected from each nurse educator through a

pre-interview, a paradigm case interview, and a final interview.

1. Pre-interview

The pre-interview was conducted by phone. This interview reviewed the description of the study for the teachers, and answered their questions concerning the research interviews. Phenomenology describes knowledge as arising from reflection on experience (Boyd, 1988). Introducing the interview plan to the teachers prior to the paradigm interview gave them the opportunity to reflect on their experience, and to select a paradigm case which they wished to share. The opportunity to reflect on the experience is especially important for teachers who are at the expert level. Benner (1982) notes that the verbal descriptions of expert nurses can be difficult to capture because of their deep understanding of the situation. The reflective period provided by the pre-interview assisted expert nurse educators to describe their paradigm exemplar.

2. Paradigm case interview

The research was conducted through collection and analysis of the paradigm case exemplars of experienced nurse educators. The paradigm case exemplar was used by Benner (1984) to study the characteristics of expert and novice nurses. The paradigm method has been used in nursing to study: nursing students' perceptions of caring/uncaring nurse behaviours (Chipman, 1990); the meaning of change to

individuals in the academic setting (Davis, 1991); patients' perceptions of caring and noncaring nurse behaviours (Halldorsdottir, 1990); nursing students' perceptions of the meaning of health (Hanna, 1989); nursing student and teacher perceptions of caring in the teaching-learning process (Miller & Haber, 1992); the experience of being a returning registered nurse student (Rather, 1992) and patient perceptions of caring in interactions with nurses (Rieman,1986).

Hermeneutic phenomenology assumes that knowledge is not part of an individual's awareness until an opportunity to reflect, as in telling their story, is provided (Boyd, 1988). Paradigm case analysis is like the telling of a story. Phenomenology recognizes such stories as being capable of revealing knowledge which is contextualized, personal, never replicable, and full of life experience (Bergum, 1984, p. 49).

The experiences of expert clinical teachers arises from their living through events and experiences. The paradigm case interview consisted of asking the teacher to share an exemplar in which caring or not caring for a nursing student made a difference. This interview was audiotaped and transcribed by the researcher. Each interview focused on obtaining the individual teacher's perspective and thus required the researcher to ask questions to clarify the teacher's meaning. The paradigm case interview is based on

the method described by Benner (1984). The participants were given the following instructions:

a) describe an incident or situation from your clinical teaching experience which taught you about the nature of caring in the teacher-student relationship

b) describe the context of the situation

c) describe why you felt that this incident or situation was significant to developing your understanding of caring in the teacher-student relationship

d) please do not stop until you feel that you have discussed the situation as fully as possible

The phenomenological strategy of bracketing was employed throughout the study. Bracketing entails the setting aside of the researcher's assumptions both prior to and during data collection (Swanson-Kauffman & Schonwald, 1988). By reducing the researcher's own assumptions, the reality of the informant can be portrayed.

In an attempt to bracket the researcher's perceptions and biases, and thus to be open to the perceptions of the teacher's, a review of the literature was conducted prior to initiating data collection (Swanson-Kauffman & Schonwald, 1988). The researcher has read extensively on the topic of caring in nursing, and caring in nursing education. As a nurse educator with twelve years of clinical teaching experience, the researcher has recorded her own reflections on caring in teacher-student relationships to assist in

bracketing out pre-existing biases (see Appendix D).

A pilot study with a nurse educator was useful in setting the goals of the paradigm interview. The paradigm interview was particularly revealing about the teacher's practices and beliefs in regard to caring. The pilot study assisted me in identifying some of the ways in which my interviewing skills could be enhanced (e.g., I did not always seek clarification for statements which I later discovered were unclear).

In order to bracket assumptions during each interview, the researcher made a continuous effort to adhere to the following three assumptions of bracketing (Swanson-Kauffman & Schonwald, 1988):

1) the researcher's own reality is valid but may not be the reality of those we seek to describe

2) the researcher is capable of eliciting and hearing the reality of the informant

3) the personal stories of the informants will express a reality which is sufficiently unique that any a priori assumptions of the researcher will not influence interpretation

Intuiting is a strategy of phenomenological research in which the researcher grasps the other's reality by being open to the other and by considering the other's reality as a possible reality for oneself (Swanson-Kauffman & Schonwald, 1988). Validity in the data collection phase is

enhanced when informants are assisted to speak freely and reflectively about their experiences. The credible researcher is one who:

1) is attentive to the verbal and non-verbal expressions of the informant

2) believes that the informant is an expert about the phenomena because the informant has lived the experience

3) is capable of assisting the informant to reflect on the meaning of events as they are shared (Swanson-Kauffman & Schonwald, 1988).

The evaluation of a good qualitative interview is described by Swanson-Kauffman and Schonwald (1988) as one in which the informant states at the end of the interview that they have nothing more to add, and one which they describe as helpful in making sense of their experience. Many of the participants expressed this belief.

3. Final interview

A final interview was scheduled for the purpose of clarifying perceptions of the paradigm interview and to share the emerging categories with the teacher. A typed transcript of the interview was mailed to the teacher prior to the final interview. The participants were asked to review the transcript prior to the interview. The teachers were informed that an opportunity will be given to expand or clarify their statements from the paradigm interview.

Appendix E illustrates the instructions that were

mailed to the teachers with the transcript of the paradigm interview. It was assumed that the teachers would reflect on the paradigm case between the paradigm interview and the final interview and thus enhance the validity of the data collected (Swanson-Kaufman & Schonwald, 1988). Mailing the transcript before the final interview will facilitate this process of reflection.

The transcripts were pre-coded by the researcher. During the final interview the emerging categories were shared with the teacher. The teacher was asked to reflect on the researcher's interpretation of these perceptions. This sharing of data with the teacher is a form of internal verification, which allows the researcher to clarify interpretations, and allows the teacher to validate the researcher's interpretation of their paradigm case (Boyd, 1990; Swanson-Kauffman, 1988).

4. Field notes

Field notes were written by the researcher following the interviews. Field notes recorded observations, theoretical notes, methodological notes and personal notes (Wilson, 1989). These field notes assisted the researcher in identifying the context of interviews, deriving meaning, critiquing interviewing techniques, and analysing the researcher's reactive response to the interviews.

5. Reflective journal

The researcher also maintained a reflective journal of

the research process, recording the researcher's subjective responses in order to identify and manage observer bias. Reactivity in qualitative research involves both the informant's response to the presence and behaviour of the investigator, and the researcher's response to the research process. Sources of reactivity in qualitative research include the researcher's personal characteristics, demeanour, goals, roles ascribed to the researcher by the informants and the researcher's overidentification with the informants. Glaser and Strauss (1967) recommend that the researcher remains continually self-reflective in order to minimize reactivity. Reactivity analysis was necessary in assisting the researcher in maintaining objectivity.

Sample and Setting

The strategy of gathering and analysing data is described by Swanson-Kauffman (1988) as the analysing phase of phenomenological research. The identification of the population from which informants will be selected is the first step of this phase. The population was clinical nurse educators in university nursing education programs. The sample size was nine teachers.

Sample inclusion criteria were determined in order to meet the need to recruit clinical nurse educators who are beyond the novice stage. Paterson (1991) describes novice clinical nurse teachers as lacking the cognitive and

experiential frameworks necessary to interpret situations accurately. Similar to Benner's (1984) research in novice-expert nurses, Paterson's novice teachers were unable to supply complex interpretations of clinical teaching situations and relied on the feedback of others to structure their teaching. Paterson also noted that experience in clinical teaching in settings other than nursing education, was a factor in the teacher's growth beyond the novice level.

The sample was selected to meet inclusion criteria of:

1) a minimum of five years of clinical teaching experience. Benner (1992), in a study of critical care nurses, recognized that some critical care nurses with less than five years experience in critical care nursing, but with considerable experience in other clinical settings demonstrated many examples of proficient practice.

2) at least one year experience in clinical teaching in a baccalaureate program. This will ensure that the teachers have a variety of experiences in nursing clinical education, and have had an opportunity to reflect on that experience. Paterson (1991) notes that teachers often did most of their reflecting on their teaching in the summer months.

Teachers were recruited by approaching faculties of nursing in the City of Winnipeg. A copy of the research proposal was sent to the Dean or Director of the University of Manitoba, Faculty of Nursing, the Health Sciences Centre

School of Nursing, and the St. Boniface Hospital, School of Nursing. The researcher asked the Dean or Director to nominate faculty who met the sample inclusion criteria.

Teachers nominated by the Dean were phoned by the researcher to determine their interest in participating in the study. This phone call constituted the pre-interview. The teachers were sent a description of the study (see Appendix F). This description of the study included a detailed explanation of how the anonymity of the subjects will be protected, as well as the security measures to be taken with audiotapes, computer files, transcripts and field notes. Prospective participants were informed that transcripts of interviews would be shared only with the researcher's thesis committee members.

The volunteer teachers were allowed to select a setting for the interview in which they were most comfortable.

Ethical Considerations

The study proposal was approved by the Ethical Review Committee, University of Manitoba, Faculty of Nursing. Once the approval of the Ethical Review Committee was obtained, a letter (see Appendix G) and a copy of the proposal was sent to the Dean of the University of Manitoba Faculty of Nursing; the director of the Health Sciences Centre, School of Nursing; and the director of the St. Boniface Hospital,

School of Nursing. This letter requested the Dean or Director to nominate potential study participants who met the sample inclusion criteria.

Confidentiality and anonymity of subjects were protected by the following procedures:

1) all teachers were identified by a code number on all transcripts and in the final report;

2) only the researcher knows the identity of the teachers;

3. the list identifying the teacher with the assigned code number is kept in a locked drawer, available only to the researcher;

4. audiotapes and transcripts are stored in a locked drawer, available only to the researcher, for a period of 10 years;

5. information that might reveal the identity of the teacher will not be included in the final report (e.g., which facility they are employed at).

Subjects were informed that participating in the study may be of no direct benefit to themselves. However, the results of the study may benefit nursing education. Subjects were also informed that the study required three to four hours of their time. Subjects were informed that they were free to withdraw from the study at any time with no repercussions.

This study involved some individuals who are colleagues

of the researcher's thesis committee. Participants were informed of the names of the members of the thesis committee prior to obtaining their consent to participate. Participants were informed that the thesis committee members will not know who chooses to participate or to not participate in the study.

Participants were invited to a debriefing session prior to the thesis oral defense. Although the participants had an opportunity to clarify their paradigm exemplar in the final interview, they deserve an opportunity to be exposed to the research report prior to it being shared with a wider audience. The debriefing took place individually if requested by the participant. All participants were invited to the thesis oral defense and received an abstract of the study.

Limitations

Limitations commonly ascribed to qualitative research focus on questions of researcher bias and validity. The minimization of researcher bias is a guiding principle of this research design. Procedures to minimize researcher bias include: the strategies to bracket the researcher's viewpoint, sharing emerging themes with the participants of the study, and validating data analysis with the researcher's thesis committee.

The potential for reactivity of the researcher was

managed through the strategy of keeping a reflective journal of the research process. This record of subjective responses assisted the researcher in identifying and managing the researcher's responses to the research participants and the data.

The potential for reactive responses of the research participants, where the behaviours and responses of the participant is influenced by their awareness of being a research subject, can also be a concern in qualitative research. Each volunteer was given the same information about the purpose and method of the research study. The credibility of the data collection is confirmed in the appraisal of the results of the study.

The nature of the sample population is another limitation of the study. Those that volunteered to participate in the study may attach more importance to caring in teacher-student relationships than those who chose to not participate. It is possible that those who did not choose to participate interpret caring in nursing education differently than the volunteer population.

Data Analysis

The phenomenological strategy of intuiting includes the analysis of the individual accounts of reality into a summary of the phenomenon. This strategy involves critical reflection of concepts as they emerge, discussion with other

researchers, and analysis of the researcher's own thoughts and feelings (Swanson-Kauffman & Schonwald, 1988). Saturation of categories occurs when new data fits previously defined categories.

Transcriptions of the interviews were reduced by thematic analysis. Hermeneutical phenomenology requires that the researcher approach data collection and analysis with an openness to the data, and without preconceived expectations of the data (Rather, 1992). For this reason, an open coding system was developed as data analysis proceeded. The goal of hermeneutic analysis is to discover meanings and achieve understanding (Rather, 1992). Rather (1992) describes the task of the hermeneutic researcher as the seeking of commonalities in meanings, situations, practices and bodily experiences. Data analysis requires the identification, and linking, of multiple common meanings, which are then grouped into themes. Themes are then grouped into overall or "constitutive patterns" that describe the phenomenon holistically (Rather, 1992).

Hermeneutic analysis was achieved by following the steps outlined by Collaizi (1978). These steps are as follows:

a) The transcripts of the interviews were read holistically.

b) Statements were extracted from the transcripts which directly related to the phenomena under study.

c) Meanings of the extracted statements were determined by spelling out the meaning while using the original words and description of the participant.

d) Clusters and themes were formulated from these meanings. They were validated by referring back to the participant's original description. Discrepancies in themes or outliers were noted.

e) An exhaustive description of the phenomena under study was provided from the integration of the above results.

f) The description of the phenomenon was returned to the participants and validated by asking if the description captures the true meaning of their statements.

The management of issues of reliability and validity in qualitative analysis reflects a level of controversy which is likely the result of both the variety of methods in qualitative research, and the evolving rigor of the methods. Morse (1989) suggests that the establishment of inter-rater reliability is antithetical to the aims of phenomenology, and that validity is established by giving the analysis to the informant. Rather (1992), however, utilized a team approach to the coding and interpretation of interviews. This study utilized the thesis committee as the data analysis team.

Interpretive reliability was established as intra-rater reliability by re-coding transcripts once category

definitions appear to be finalized. Stability of the coding system will be evaluated by re-coding a percentage of the transcripts once all transcripts have been coded. Validity was assessed in the form of face validity, and by comparison with other studies of caring in nursing education. Coded transcripts were shared with teachers in the second interview to ensure validity of the analysis (Morse, 1989).

The final strategy of phenomenological research is the describing of the model derived from the paradigm cases. The model should apply to each informant but does not need to describe the complete story of each informant (Swanson-Kauffman & Schonwald, 1988, p. 105). The test of the identification and description of the components of the model is described by Swanson-Kauffman and Schonwald (1988, p. 104) as the ability of anyone who has experienced the phenomenon to be able to use the model to analyze their own reality. The description of the model is the subject of Chapter Five.

Summary

The relationship between clinical teachers and students has largely been examined in research focusing on student clinical anxieties and anecdotal literature about clinical teaching. The predominance of students' fears in clinical education appears to be strongly related to the behaviourist model of education which focuses on teaching by evaluation.

This has resulted in a clarion call from reconceptualists such as Diekelmann, Bevis, Paterson, Tanner, and Watson, to explore and define the elements of caring in the teacher-student relationship in nursing education. The caring relationship between teachers and students has little empirical foundation and requires further study to identify the nature of this relationship. This research contributes to the knowledge in this area.

CHAPTER FOUR

FINDINGS

The nine participants in this study shared paradigm stories from beginning or recent years as clinical teachers. This chapter provides a description of the characteristics of the participants and the context of the paradigm stories. The chapter includes a description of the findings related to the phenomenological concepts of experience, perceptions, modes of awareness, and expression. A summary of major findings concludes the chapter.

Characteristics Of The Sample

The nine participants had between four and fifteen years of experience in clinical teaching; and between one and eight years of experience in clinical teaching in a baccalaureate nursing program. The educational preparation of the participants was a Baccalaureate in Nursing (2); Masters in Nursing (4); Masters of Arts (1); Masters of Education (1); and a doctoral degree in nursing. The age range was between 32 and 52 years.

The paradigm stories were drawn from both the participants' early years as clinical teachers (4) and more

recent years (5). The context of the students' situation as related within the paradigm case was not related to the experience level of the participant. Six of the paradigm stories focused on students whose clinical performance was affected by such personal problems as a history of physical abuse, bulimia, low self-esteem, and difficulties in a relationship. One story centered on the participant's relationship with a student who was managing a client's disclosure of an abusive relationship. One paradigm focused on the relationship with a student who had difficulty dealing with an error committed in clinical practice. One participant shared a paradigm situation in which the cause of the student's problem was unknown, and the student withdrew from the course without resolution of the issue.

The clinical courses included medical-surgical units, psychiatric units, clinic settings, and community health settings. Seven of the participants were clinical teachers physically present in the clinical setting with the students and their clients. The others were resource teachers, located at an institution other than the clinical agency. All of the paradigm situations involved interactions with students outside of the clinical practice settings.

The Caring Environment

Caring in nursing education was experienced by the participants within specific contexts and cultures. The

environmental variables which determined the participants' experience of caring are described in this section. They include the context of caring and the culture of the school.

The Context of Caring

The nature of the clinical setting can pose unique challenges to the students and clinical teachers. One participant reflected on the sensitive nature of teaching in a mental health setting and the need to be alert to students who over-identify with the client's emotional problems.

> It is a setting that people think, that if they are in any way vulnerable, and so many of these women are vulnerable...here they are, one foot in the door. Some of them have the sense that they may belong here. Particularly when they start seeing behaviours in the patients that are similar to the way they think. That could be me....it is that personal identification with the client group and the student group. As the clinical teacher you have that extra burden to carry around.

The participants referred to the context of caring in nursing education as more than the physical setting of the educational experience.

> It went beyond this protectionism, to people working co-operatively in a healthy adult way, as opposed to doing it for you... Providing a caring environment... Clinical teaching is not just me. There's a whole host of other people.

Paramount in this context are the people who offer support, and contributions to the learning experience. The participants received support from a variety of people in the clinical area.

> I sought validation for what I was doing. I needed some support. I sought from the CNS [clinical nurse specialist]...I got some support from her...validation... She is the kind that supports you in what you are doing.

The participants believed that teachers have a responsibility to create an environment which is conducive to learning. This includes intentional acts to make students feel comfortable in the setting and strategies to enhance the students' ability to think clearly. One participant described matching a student with a staff member who had experienced personal problems. At times, the caring context was provided in response to a stressful situation experienced by students in the clinical area.

> Setting a climate that they can talk about what they know and don't know, and what they are interested in, and what they have questions about. And combining that with what I know they need to learn and what they need to be able to do. Trying to get the two things together. Meeting their needs and the needs of having to evaluate. The climate is really important.

> Sometimes when students have tried their best, and just have had enough. Their anxiety or stress is so high, or someone has just taken a strip off of them, you are there after. Come back to roost and it will be OK....No matter what happened out there you are still worthwhile and you can feel safe here. You are OK here, no matter what has happened. Chill out. It will be OK.

The Culture of the School

Norms and Values

An aspect of the caring environment which was external to the clinical setting was the culture or ethos of the

school of nursing. The participants stated that each school of nursing has norms and values which influence both teacher and student expectations. Decisions teachers make in regard to caring are influenced by the cultural ethos of the school. Some schools of nursing structure clinical learning so that the teacher teaches in isolation from peers. This practice affected the amount of collegial support available to teachers in their teaching.

Ritualistic practices, particularly in regard to evaluation of students' clinical performance, determine the expected responses of a teacher to student difficulty. Several participants stated that, if they wished to make decisions which were in opposition to these rituals, they faced peer pressure and conflict. This conflict at times resulted in the participant compromising what he or she believed to be a caring resolution to the student's difficulty.

> One of the colleagues that I work with, we have very different styles. Sometimes she has berated me for my style. Her approach would not work for me. You have to develop your own.

The participants reflected on the effect of the values of the school on the ritualistic practices which become a part of the school's ethos.

> We have to be comfortable with our own judgements too. Because we are on the line, our performance is on the line. If I evaluate this student as fine, and they are really not, then I am incompetent. Maybe we set up this very rigid authoritarian structure, or [are] very heavy into evaluation from day one, to be able to justify

> everything that I think about a person. I guess over time you learn to be comfortable with the fact that it is not necessary.

The norms and values of the school determined the priorities assigned to teaching, evaluating student performance, and to the types of relationships established with students. Although participants came to value their individual teaching styles and methods, there was recognition of the effects of the cultural ethos on their ability to sustain those practices which they valued.

> If you feel valued and important you are going to feel good about yourself, and you are going to do a better job teaching and you are going to be able to put in that extra time. Do those things that are caring for them. But if you are feeling that you are not valued, it is not really that important, those extra things to help them learn may not be done.

> The question might be would you do that the next time. If you were repeatedly getting no support, or criticism for this kind of relationship, this kind of investment in student learning. After awhile you might become rewarded to not do those kinds of things and might in the long run become more superficial. You might do a rebound thing, where you are trying to really get your needs met through the students. It may not look like a deficit. It may look like an over-investment in the student's life, clinical work. And lack of respect for boundaries. That might be a side effect that might be less obvious initially.

Three participants talked about the negative and positive outcomes of passing on information about individual students to colleagues. These participants expressed concern that sharing information about students could result in a bias. They were concerned that they maintain confidentiality of the personal information they learned

about students. They valued, however, the opportunity to make suggestions that would facilitate the student's growth in their next clinical course.

> I think I basically said to buddy her with a caring staff nurse. For the teacher to give her a little extra help. That she would be fine, but just to let her have a little more than one day for the initial orientation. She would need extra time to feel comfortable.

Peer Relationships

The majority of the participants reflected on the effect of the cultural ethos of the school on their development as teachers about how to teach and how to make decisions about students. There was an expressed need to learn from other teachers. Two participants felt that learning to teach in isolation can limit teacher development and the sense of support.

> I think they used to work in teams. The people who worked in that system tell me that it was a lot easier to get new people confident in their role, because there was a lot of meeting and sharing. The way that teaching has been done here recently, people are pretty much on their own. I think they sort of blunder along, a lot of them, until they find a style that works for them. I'm not convinced that its a style that they are comfortable with. It's the one that works for them.

> ...one of the barriers that I see is the relative isolation of one's role as a ... teacher, from other colleagues, from other resources. It tends to be a job that requires more individual work, there are real nice parts about that in terms of the opportunity to look inwards. Care for your own ideas. Care for your own perceptions. That can get to be a closed system. A teacher can become a closed system. There is a risk. Some of this comes through the student, but that is only one channel. And my sense is that there must be a

healthier way of doing this.

Participants who were accustomed to having access to other teachers for support and discussion valued this contribution to their development as teachers. Collegial support was seen as conducive to sustaining their ability to respond to students in effective and caring ways. The support of colleagues offered the confirmation that they were valued by their peers.

> ...at the time of this situation, I was part of a team. I was closer to some members of the team than others, I did share the support of that team. There were individuals with more experience in the system than I had. Or more individuals who could talk it through in terms of their life experiences....It gave me confidence. They would say, that's important, it is a good thing that you did that as well...sharing my perceptions. "Yes, the student is strong, you can trust him. I have seen him in my work too. He is capable." Just some validation. I appreciated it... It was not anything really major. It was subtle, gentle feeling that we are with you.

> I could not have done it in isolation. You learn all the time. But to try to proceed without input from any place else, I don't think that it is effective. I think I would go up the wall. Many people here are over achievers, so we need to make sure that we are doing it right, and are we doing what we should be doing. And how can you find that out unless you go out of your office and chat with other people?

Evaluation Rituals

Several participants reflected on their perception regarding the nature of the evaluation of students' clinical performance which changed as they gained experience in clinical teaching and became more comfortable in their role as a faculty member. Most of the participants shared the

perception that the experience of clinical teaching can entail constant evaluation of student performance. The participants stated that they believed as beginning teachers that their competence as teachers was judged by the accuracy of their clinical evaluations.

> Initially, I felt that because our evaluations very much depend on each other... I felt a great deal of pressure, I must evaluate from day one. Over time I began to appreciate that one posting may be good and another may not be good for whatever reason.

Failing to follow the standardized evaluation rituals of the school could result in self-doubt and pressure to conform. However, being a witness to the success of another teacher's nonconformity could serve as permission to do things in a different way.

> ..we all started with this same way of doing things. Our own personalities started showing through. One of my colleagues...I saw her once with a group of students, just sitting there chatting away. At first I thought: oh, she must know them from somewhere else. Then I realized that she was just interacting with them. She's not putting on this teacher front. She's just interacting. It gave me permission to do the same. And that was actually a pivotal time too. There are a lot who...are unable to interact with students in a collegial kind of manner. But those who did, I found a real inspiration, because I saw how the student's responded to them.

The faculty's response to student errors was described by one participant as a determinant of the evaluation processes.

> We have that expectation that it is not OK to make a mistake, and we have that ethical dilemma that we really can't make a mistake because it can harm someone. But it depends on the type of mistake.

> People are going to make mistakes. We all have in our practice. It is silly to have this expectation of this neophyte, who certainly is going to make mistakes, that they can't make mistakes. Oh, it's terrible.

Conceptualizations of Caring

Caring as a Human Trait

The participants valued those expressions of caring that fall within the realm of caring as a human trait. Parenting role analogies were often used to differentiate human caring from professional nurse and teacher caring.

Several participants referred to "mothering" as an expression of caring for students. Four of the participants related their experiences as parents as pivotal to their caring for students. One participant described "mothering" as including actions to promote the growth of students. Another participant believed that "mothering" was an inappropriate but instinctive response to younger students.

> You try to assist them to become independent, but to become comfortable in attaining it. That is the nutshell. I do it in different ways. Probably through allowing them choices, allowing them to make decisions, allowing them a lot of independence. Allowing them to make mistakes and to take risks. To do things that you know darn well are going to get them into trouble.

> I prefer not to deal with beginners. Because I would over-mother the little darlings... I'm not very good at letting people go out and commit--- and make blunders, because they are painful. I would rather spare them. I'd rather find a way to spare them that pain.

Participants valued students' caring behaviours which respected the personhood of others. They used terms like mothering, natural, individual, and human to describe human caring for students.

> He [the student] was responding in a very human way. A human connection with that woman, that probably allowed her to trust him enough to say something.

Caring for students by the participants often arose from the students' disclosure of personal information related to a life crisis. The participants generally felt called to respond to these students from their perspective of human caring. The participants described situations in which they sometimes struggled with conflicts between their assumed role as a teacher, and their instinct to respond in a caring manner. Usually the instincts to care prevailed. The participants responded to these students from their perspective of what it means to care as a human being.

> ...it is part of being a human being. It is as simple or as complicated as that.... having someone in your office pouring out their guts, and having to respond or attend to some part of that. That you can help with. That you can be involved with to make a difference.

> It was hard for me. It was hard at first because this was a student. You left that aside, and saw this person. But it evolved rather naturally for me in that I felt that she needed help and I care for her and about her. I resolved that I would see what I could do.

One participant shared a paradigm story in which she was unable to resolve her conflict between her role as a

teacher and the human caring that she felt was a part of her being. This story occurred in her early years of teaching. For this participant, the paradigm was a negative exemplar. She described a student who manifested classical signs of anxiety. The participant ignored the student's behaviours and continued to concentrate on the clinical teaching goals. Reflection on this paradigm situation lead to a change in the participant's role definition.

> This one has always bugged me. Because I didn't know what my role was here... I sort of suppressed all of my previous instincts as a practising nurse, who would have asked the therapeutic questions like, is there anything you would like to tell me, are you having any difficulties, why don't we just go for coffee and chat...I chose very much to stay in my clinical teacher role. Which was to attend only to the reason why she was interacting with me, which was to do this project. I have been really ticked off with myself ever since. For not having enough courage to follow through with what I've always been convinced that I should have done.

This participant conceptualized human caring as distinctly separate from the role of the teacher. Segregation of the two roles appeared to be necessary to resolution of her role conflict.

> I guess I made a decision that I am going to chuck the teacher role and become something else. But certainly I felt that I wasn't being called on as a teacher. I was being called on as a human being... I said to myself if I were ... in this position, I would hope that someone would care enough about me as a human being to respond in a human way. And I really felt it was my problem. Because she came to me and she asked me.

Caring as a Moral Imperative

This conceptualization of caring centres on maintaining the dignity and respect of students as people. This perspective encompasses perspectives of caring as a moral virtue, a moral imperative, or an obligation. Participants holding to this view experienced satisfaction when responding to students in a caring manner. They experienced guilt when they failed to meet their self-expectations of caring.

Students were also expected to demonstrate caring in their interactions with clients. This produced a dilemma for participants who reflected on the difficulty of working with students who appeared to not care for their clients: caring was perceived as essential to nursing, but was not evaluated as essential to passing the clinical course.

> It makes me wonder why they are nurses. It is not a substitute for being a mother, that's what women do, they care. I don't believe all women care or all men don't care. But to be a good nurse you have to be a caring person. That has to be the motivation. You have to be compassionate, you have to care about the human condition. If you don't, I don't know why you are here.

The other dilemma presented by this conceptualization of caring was the student who appeared to care for clients but lacked the intellectual ability or competence to meet expectations of a good nurse. Three participants seemed to conceptualize caring and competence as mutually exclusive characteristics of a good nurse.

> Sometimes it is the student who is not the brightest that I admire most. Sometimes other things are more important. It comes down to caring. ...one of the students in our last class that I valued very highly, she got into a lot of trouble towards the end. The reason that I really valued her was that she was one of the safest people that I ever encountered. She wasn't the brightest. But she would always make sure that she was safe. She really cared about her patients. She was wonderful in many ways. But she had academic difficulties.
>
> For people who care and are inept, I am willing to give buckets of time. My preference is to produce a nurse who is intelligent and caring. The caring piece is real important to me.

Caring as an Affect

Caring was sometimes described as an emotion and a feeling of empathy.

> The caring part was that I was able to see her for the individual that she was. Able to bring to her some things that could help her be the kind of person that she wanted to be. Try and feel her feelings. Try and feel her experience. Recognize and accept where the individual is at. And by constructive empathy, trying to work with her.

The emotional attachment and empathy for the student produced difficulties for the participants when the student failed to meet performance expectations. In order for one participant to resolve this conflict, she had to de-emphasize caring for the student and focus on the conceptualization of caring as an obligation for client welfare.

> My concern was that a failure is imminent even though I said that we could do this. I used to dream about her in this situation and what she was going through. What she was going through on the

> ward...I just really worried about her, not necessarily what she would think of me for failing her, but what would happen to her? What would this next blow do to her? I felt this responsibility of representing the school I was working for... that the students would care for the patients in all respects...I couldn't take over for her so I started to feel this sense of responsibility for the client.

Caring as an Interpersonal Interaction

Reciprocity

This conceptualization of caring recognizes reciprocity in the teacher-student relationship, where both are enriched by the process. The participants described the need to exhibit caring for their students in order to transmit the practice of caring in nursing. This caring connection was perceived as role modelling and dialogue.

> I don't mean that you have the same type of relationship with all of your students, but for those students where there is a defined need, sitting right beside you, what they need from you is maybe not what you can teach them about health assessment, as much as, for someone to hear what they are saying, understand and appreciate where they are coming from, and accept them as the whole package that they come as. Teaching is about connecting with people on more than just the academic fact that you are trying to impart.
>
> If there isn't an honest connection, then the job becomes more hollow. And that is true in classroom teaching, not just the clinical. That when I have more frank dialogue with students in classrooms, whatever the topic is, I come away excited, enthused, stimulated.

Reciprocity for one participant entailed that helping students would eventually result in their success in the program. She described the frustration she experienced when

her caring did not result in the student's success in the clinical course.

> By showing I really cared, I felt that I was committing myself to helping her. I think that is why I got upset as time went on, because I had to end up failing her. I felt that I had failed. That I wasn't able to help her.

Another participant was careful to explain the risks of forgetting whose needs are paramount, and how to "keep it clean".

> I think that it is really important in any therapeutic relationship that you remember who's needs are whose. As a faculty member teaching, I don't get much feedback. I sometimes wonder if what I am doing really connects with the real world, the clinical world, and the outside world. Those are my needs. I had to be alert to them, and aware of them. That her [the client's] needs stayed central. I wasn't getting something out of this vicariously. Because all of a sudden somebody needed one of my students.

All but one of the paradigm stories involved a personal connection between the participant and an individual student. The participants discussed strategies they employed to get to know students in general, specific strategies employed when they began to suspect that the student had a problem that was interfering in their clinical practice, and the consequences of getting to know the student. The level of knowing about the student influenced their ability to trust the student and the selection of strategies for caring.

> At first she was sort of emotionless, which struck me, like she wasn't telling a story, she was reading a grocery list. There wasn't a lot of inflection in her voice, or emotion. I got the

> sense of this not very functional home she was coming from. Some of it was just the timing, or something triggered her in the comment that she just responded. I am not sure why. After that I had more information to work with, what the situation was.

Mutual Trust

Mutual trust between teachers and students was perceived as important to establishing caring relationships and maximizing the students' learning experiences. Several participants discussed the need for students to trust themselves, believing this to be critical to students' self-confidence and development of competence as a nurse.

> I felt that the first week she was so nervous that she communicated it to her patient. And the patient didn't have any confidence in her at all....you can feel really nervous, but try not to let that get across to the patient.

The participants employed a variety of strategies to develop the students' trust in the teacher. The participants judged the students' level of trust in the teacher by the students' willingness to ask questions, to share their clinical experiences, and to express their uncertainties. The participants perceived students' trust in the teacher as essential to students' ability to learn from clinical practice.

> ...if we care about students, we do a better job evaluating them. It is sometimes worth the care and effort we put in. Those caring efforts, those things that address their needs. You do a better job: you help to relax them to say what they really think, and feel. They are willing to discuss situations with you. Willing to discuss their uncertainties. And ask those silly questions. You want them to ask those silly

> questions. Something that they should have learned in first year and they never learned it. You can say it's all right, you didn't learn it, let's learn it now.

Knowing the Student

Knowing the student influenced the teaching strategies selected by the participants. One participant related a paradigm story in which she and the student were called upon to deal with a client's disclosure of physical abuse.

> It gave me an opportunity to get to know this student in a more in-depth way. Because we had to talk about the issues... In my opinion he did outstanding work. ... his honesty and his compassion were really called on in that situation...What I learned through that, was in order for him to do good work, I really had to be tuned into his emotional needs. Helping him sort through things.

The participants reported a variety of strategies which they used to get to know students. These strategies included informal talks with the students over coffee, discussions in the teachers' offices, and through interactions on the clinical units. Knowing the student's usual behaviour and gestures enabled participants to identify cues that the student was experiencing difficulty. Some students, however, were difficult to get to know.

> I found my interactions with her in the office irritating at first because I couldn't get through. There was this wall. I felt that I was trying to help and: how dare you not accept what I am trying to give you. I knew that there was something here, but I wasn't asking the right questions, or not taking the right approach to tap whatever it was that was going on. I knew that time was ticking away. I felt that unless I found out what was going on here, her clinical experience and hence my evaluation would not

> reflect what was going on. Or what she was capable of.

The participants acknowledged that there were constraints to how well they got to know students.

> The focus is on the patients and their care. You look for hints about them as people. Their attitudes. Build on that. What are their preferences... What kind of things they think... A few of them you might get to know. But most of them, no. Some of them I can't even remember.

> It is very hard to care for people on a mass basis. Friendships, families, I don't have a huge circle of friends. I have cordial relationships with my colleagues here and I care about all those people. They don't number in the hundreds. The students here number in the hundreds. If you cared for them, about them, at the level of intensity that you cared for your family or your friends, you would have nothing left. You would loose it.

Previous association with the student was identified as a special situation in three of the paradigms. An initial concern cited by the participants was that this previous knowledge could bias their response to the student in some way. One participant expressed the belief that she cared more because she knew the student. Knowing the student from a previous course or from another setting influenced the participants' judgements about student errors or shortcomings.

> I guess what I had seen in her, well I was aware of the clinical grade that she got in the previous term, and she had done very well. I had her clinically for a couple of weeks, enough to know that she was an intelligent person and that she probably didn't present herself as well initially as she might. She's one of these people who you don't get a really good first impression.

For one participant, the contrast between the

previously exemplary performance of the student and the student's borderline performance in the paradigm case, caused the participant to reflect on her expectations of consistent performance.

> I think, as faculty, we can't forget that our students are people. We don't necessarily know all about what is going to affect how they do as a student, and eventually as nurses. I would like to think that I am sensitive to that...I think I made several judgements about her along the way that in fact she was capable, but for some reason at this time she was minimally satisfactory.

This paradigm situation prompted the participant to reflect on the subjectivity of her evaluation of students' clinical practice. In spite of having a detailed clinical evaluation form, the distinction between passing and failing became less clear when the participant considered the student's previous performance.

> I guess it is having to make a judgement about somebody beyond what you are actually seeing. I am told that a person has to do ABC, and they have to do ABC at this level. And they do ABC almost at that level, or sort of at that level...If they don't do it they fail. If they do it, they pass... we have this other information about our students to analyze. It doesn't necessarily mean that at that moment they should go [fail]. Maybe it does. But it is not as simple as that...That is what is significant to me about the situation...look at each student individually, and try to figure out what is going on. Make individual judgements on their situation.

Knowing with Reflection

Most of the participants identified previous experience as influencing their ability to get to know students and to predict the usual responses of students at a given point in

the educational program, or in a particular clinical setting. This knowing with experience helped the participants to anticipate problems, to identify students who do not fit the usual patterns, and to select strategies to help these students.

Two participants kept journals in which they reflected on their experiences as teachers. One participant read her journal entries to prepare for the paradigm interview. She believed that this entry had helped her to recognize the objective information she had about the student in the paradigm story. Reading the journal reminded her that she had grown in her conceptualization of teaching and learning.

Reflection on their experiences as teachers enabled the participants to formulate general expectations of what students can do and to anticipate those aspects of the learning experience which may pose difficulties for students. Students who did not fit the expected pattern prompted the participant to respond in an individualized way to the student.

> I think you have guidelines which eventually you expect students to be at a certain level. Most of them fit that. I tell the students the first week on, I realize you haven't done these skills for awhile, because of that I do expect them to get me for the first time with an IV med [intravenous medication], dressing.
> She seemed to be more nervous than the usual student, she always wanted me to be there. Most of the time students at this point in time, you go through it once with them and the second time they come much more confident. You are just there to make sure they know what to do. I remember her asking several times, to make sure that I would be

> there. With her basic skills, even doing a blood pressure, I would see her just shaking. More so than the usual.

Knowing with reflection influenced the participant's beliefs and attitudes about why it is important for teachers to know students as individuals.

> You know from whence they come. So we talk about teaching, meeting individual patient needs, but I don't think that we always do a good job of that with students because we have this generic standard. Not everyone comes from a background that is supportive and has the inner resources to mount an attack on the program. If you have the inner resources, you can at least investigate more to find out, to at least know if you are in the ball park. I think if you know more about them you have that much more information to make decisions and plan and try to be effective.

> What I learned from having her, is ...if they are near the end and they have one bad day, sometimes you are too quick judge someone ... without doing a little more identification of what the problem is. Colleagues sometimes say what you should do with the students. But you have to go with your own instincts. Assess the situation and not just do what someone else has done.

<u>Knowing the Teacher</u>

> ...she said that I had a reputation that I didn't jump on students right away, that I gave them time. She must have felt safe.

The participants felt that, just as teachers needed to get to know their students, the students were concerned that they get to know the teacher. Knowing the teacher was viewed as important to students because it reveals the teacher's expectations of students. When students can clearly identify a teacher's expectations, they can feel more secure and confident. The participants described an

increasing awareness of the importance of their behaviour which occurred as they developed rapport and trust with students.

> Your own behaviour is critical. You need to smile. And look at them. Get to know their names. Ask them a little about themselves. What they are interested in. Showing you are human, you are flawed, you make mistakes. Talk about errors you have made in the past, and what you have done about them as well. Talk about, show them they can be wrong, and it is not going to be written on a form. Not everything they say gets written down. They have a certain amount of freedom. Try to give them as much information as possible, try to be as clear as you can about when that evaluation will be.

Caring as a Therapeutic Intervention

Caring was perceived by several participants as an intervention designed to assist students to resolve or minimize difficulties they encountered in the clinical learning experience. In this conceptualization of caring, caring occurs regardless of how the teacher feels. It is centered on the needs and goals of the student. At times, it entailed intervening in the personal lives of students.

> I spent the most part of three days trying desperately to find a place for the student to stay. Where she would be safe and have a bed to sleep on. And trying to help her. If she decided to withdraw from the course she would have to leave the country. I am sure that I burnt the most part of a week trying to help her sort through and make that decision.

The Vulnerabilities Of Caring

The participants reported that both teachers and

students can be vulnerable in teacher-student caring relationships. Many participants expressed caution about establishing caring relationships with students.

> ...it leaves both of you a hell of a lot more vulnerable. I think. Both the student and the teacher. If you have that kind of really human exchange. It puts the relationship on a whole different footing.

Student Vulnerabilities

The participants recognized that students may share problems simply because of the teacher's authoritative role. They also were aware that students might later regret exposing their problems to a teacher.

> I don't ascribe to the notion that caring means that you really just care and really flood the person with a lot of words. I am sensitive to the notion of intrusiveness...I know that I am in a (teacher) student relationship,...I know that the role I have has power. So just simply inviting, questioning, pushing something in a personal way, can evoke a response that perhaps the student may not feel comfortable with in retrospect.

> I think it might represent uncaring in a sense that how do the students see it. If her performance was affected by this relationship, she felt comfortable wanting to talk to me and it did go on to affect her performance?

One participant stated that students are exceedingly alert and sensitive to the behaviours of their teachers. She described the vulnerabilities of students in this way:

> I can still remember this clinical teacher who was so wonderful. So kind. So encouraging. She said: look and think about it...also the authoritarian ones, just the worst clinical instructors. They shape who we are, and as nurses, and how we feel about ourselves. That is

> what we are doing to students, we are affecting how they feel about themselves. We must be caring and careful about what we say and how we say it.

Teacher Vulnerabilities

Some of the participants stated that they felt vulnerable in caring relationships with students. Several participants stated that they were concerned that students would take advantage of them if they were open and caring with students. Despite this fear, only one of these participants reported that a student had actually taken advantage of her, and she believed that student to have had a borderline personality. Although they perceived themselves as vulnerable to psychological harm, several participants talked about the need to take risks in getting involved with a student's problems.

> Anytime you connect with people at any level, you risk, not just with students, you make yourself open. You don't set out to damage people, but sometimes our best intentions are not what that person needs. But with this student, doing nothing would be worse. I couldn't have <u>not</u> done anything. At a human level.

Strategies Of Teacher Caring

The participants described many acts which they perceived as expressions of teacher caring. The strategies of caring were selected to help the student deal with their personal problems and the challenges presented by clinical situations. Consideration of the student's self-esteem was a major factor in the selection of caring strategies.

Counselling Strategies

These caring strategies were chosen to explore the student's particular situation and to deal with problems. Counselling strategies included probing, re-framing, visualizing success, focusing the student, relaxation techniques, and responding to student cues. The participants were often concerned that counselling techniques were beyond their expertise, or outside of the boundaries of the student-teacher relationship. Paradigm situations from the participants' early experiences as a teacher were more likely to reveal concern about the teacher's role definition. Only one participant did not experience role conflict when selecting counselling strategies in her first year of teaching. This participant believed that helping the student in a counselling manner was consistent with her practice as a nurse, and was inherent to the role of clinical teacher.

Paradigm situations from teachers' more recent experiences as clinical teachers included counselling strategies, but without the role conflict experienced in the novice stories. While these participants usually considered counselling strategies to be part of their role, some expressed concern that they lacked the competency necessary to enact the counselling strategies appropriately.

> I think that I felt comfortable with the use of communication strategies to draw her out: talk to me about what you are feeling. That seemed natural. What I was uncomfortable with was my

> perception of the magnitude and the pervasiveness of the problem. It wasn't just a matter of: you had a bad day on the ward, let's talk about it. It was more everything from Abraham-on in the family. I wasn't equipped to handle that. In the course of those things coming out, getting a handle on what the issues were, I felt out of my league. I thought this was a problem that I could start some initial fact finding about. But the pathology underlying, I couldn't presume to understand or counsel.

Probing and Responding to Cues

Probing was a strategy selected when students revealed cues that they needed help with a problem, and when participants suspected that there was a reason for a student's behaviour. Exploration of the problem was conducted both as a strategy to get to know the student and to understand the nature of the particular problem. The participants were apprehensive about extending the probing beyond the problem identification level. They consciously attempted to avoid entering the role of psychological counsellor.

> It was more of a listening, a fact finding. Talk to me about what has gone on. ... she wasn't asking for advice, she was telling a story and I was prompting her to do that. But I felt very overwhelmed by the type of information that was coming out. ...we never talked about it in the same depth again. She would mention something about how her mother was, or whatever. She would refer to family members... I am dealing with the immediate, I understand the background, but I can't tell you what to do when your grandmother is drunk and falling out of her rocking chair. That is difficult for her, but it is not my role, and that is not what I assumed in the discussion with her.

> The participants acknowledged that perhaps they

sometimes failed to identify student cues. Several participants also admitted that they might choose to ignore students cues. The decision to ignore cues was attributed to either respect for the student, or arising from the participants' lack of resources to deal with the student's problem.

> It got to the point that I was afraid to look up and see another student standing inside my doorway. It was too much. You didn't want to turn them away. It didn't seem to be the human thing to do. But it costs. It came at a price. The vulnerability is knowing that there is a cost to caring. That it is an emotional cost. That you don't always have it in the bank... you just become more abrupt. I always try to remain pleasant. You don't ask the "why" questions any more. You just say: oh. You don't say: tell me more about it, give permission to get closer.

Two of the paradigm stories from novice teaching years illustrated that ignoring of cues arose from the participants' desire to focus on the students' clinical goals rather than to confront the student's overwhelming personal problems. In one case, the participant delayed taking action on the problem for a few weeks. In the other case, the participant did not explore the student's problem and persisted in trying to deal with the clinical objectives. The student withdrew from the course.

Reframing

The participants reported attempting to influence students' perceptions of their performance or situation by reframing the situation to the student so that it appeared

less disastrous and more manageable. Reframing was often employed as a response to students' low self-esteem and perceptions of hopelessness. Students were encouraged to consider the positive aspects of their performance or situation. Reframing encouraged students to look at themselves in a more constructive way.

> What I did with her was, when she made mistakes, after a dressing change or whatever: ... I want you to tell me two things that you did well about that. When she would start to say, well I didn't do ..I would cut her off and say, give me two good things. We can deal the other stuff after that. Making a habit of saying good things.

> She was a capable student, but had a lack of insight into the fact that she was human, that you have to make mistakes to learn. It was all very negative. In her anecdotal writing, I pointed out that if she didn't start writing something positive, she wasn't going to get the credit for submitting anecdotals...And slowly over time, she at least came to the point that she would catch herself before she would do it... and sort of smile, and get into a different pattern of thinking and reporting about herself.

Reframing was employed by one participant to encourage students to approach their clinical practice from the perspective of a nurse, rather than as a student:

> I say we are nurses now. The students always say we are students. I want them to think like nurses, they don't just suddenly become nurses. If you think as a student, you don't think as a nurse.

Predicting and Visualizing Success

Communicating the expectation that the student would be successful was considered as valuable by all of the participants. They stated that they were able to offer predictions of success to students because of their belief

in the abilities of both the teacher and the student. One participant reported using visualization techniques to assist the student to see herself as performing a task successfully. This participant encouraged students to recall previous successes and transfer the feelings associated with those previous experiences into their clinical practice.

Visualizing success was augmented by the teaching strategy of "mock runs", where the student would "talk through" a procedure or patient interaction. This strategy was chosen to help the student anticipate and visualize their client care situation. Mock runs were often selected when the student exhibited signs of anxiety in performing technical skills. A form of mock runs was also reported by one participant in helping a student deal with a particularly sensitive client problem. In this situation, the participant helped the student to anticipate the questions and problems the client might present. This allowed the student an opportunity to explore his reactions and plan his responses.

Five of the participants expressed doubt about their decision to tell a student that success was expected. Some paradigm situations, drawn from the participants' early teaching experiences, revealed that the participants had offered false reassurance. This false reassurance had apparently resulted from the teacher's failure to explore

the nature of the students' problem.

> In her case I was denying her...I didn't know what was going on in her life and she certainly wasn't going to tell me. I think that "It's OK. Don't worry" was actually very inappropriate to say to someone like her. Because I was in fact denying her fears around whatever.

The participants' doubts about expecting success which were expressed in more recent paradigm stories differed from novice experiences. Although participants relating recent narratives expressed some uncertainty that the student would be successful, they made a commitment to help the students, and took a risk that the outcome would be successful. The context of the problem did not seem to be a factor in the participant's decision to risk predicting success.

> The fact that I told her that she could do it. Once she got able to do something independently, that she didn't hurt the patient, that she could do it. That she had to trust herself. In her own abilities. She started improving over the next few weeks. So much so that I didn't have to suggest that she do further clinical experience.

> I think I gave him confidence, and the confidence I had came from the trust I had in myself, and him, and the resources. And also a genuine concern. There was a little voice in me that said: oh, boy, I hope that you [the teacher] can handle this. And another bigger voice that said: doesn't matter. You will. You better. No time to be nervous about this.

Focusing

The participants described students who were overwhelmed by the expectations of clinical practice and exhibited signs of anxiety. Focusing was a strategy selected to help these students to collect their thoughts

and to deal with the task immediately at hand. Compartmentalization was used in conjunction with focusing to break tasks into small, achievable components.

One participant described coaching the student to ask future teachers for help in focusing:

> ...that if you got in a frazzle again to tell the teacher: sometimes I do get in a frazzle in a new experience, would you help me work it through step-by-step.

Other Counselling Techniques

Additional techniques in counselling students included listening, relaxation exercises, coaching, and sharing experiences with student peers. Listening and allowing the student to vent their feelings and explain their problems was seen as a useful counselling strategy. Sometimes listening was not enough, and the student was referred to a professional counsellor. This generally occurred when the teacher felt she was unable to help the student with their problems.

> So all of these things falling apart at the same time. I didn't feel that I could really help her with. How can you give advice? That's not our role, although that's the caring part that we struggle with. When do you send them on to the counsellor as opposed to-- she's my student and I can help her with this. Its kind of a fine line.

> If it's something more, that they are so upset they are not coping any more, its not just a matter of listening, its a matter of doing something. I can't do anything, but I can listen. And sometimes listening... I've assessed that all this person needed to do is vent. I feel comfortable with that. If you assess there is more, then it's time to consider other resources.

One participant reflected on the tendency of students to refuse to go for professional counselling. She believed that students will approach the person with whom they feel comfortable. This is sometimes the clinical teacher and not a stranger such as a counsellor.

> I guess in the counsellor sort of idea, I listen, try to shorten it up and refer. It sounds like you have some problems, you might like to talk to somebody more. The classic line. Rather than to me because I am the teacher. But they still come anyway. They still come to talk. It doesn't work. They say no, I can't go to anyone. I try to give them the time but just listen. Not do any therapy. I am still ambivalent about that. But I guess listening can itself be therapeutic. They get a chance to ventilate. Sometimes I can't help but reflect, make some connections for them in their lives. But I try to avoid that.

Feedback

Giving feedback to the student was a form of caring for several of the participants. They recognized that students did not always value, or accept, the feedback of teachers. Several participants described the need to give detailed feedback to students who did not seem to trust the teachers' belief in the student's abilities. One participant felt that feedback needed to be immediate so that the student would not exaggerate a mistake.

> Rather than evaluation they need occasional validation, and immediate feedback on anything that they have done. That is where I would leave it.
>
> It is important that they feel comfortable with you. Part of that comes from trust, from immediate feedback on what they have done. Don't allow them to any time to stew. Because they will blow

things up in their mind.

Valuing

The participants identified several student characteristics which influenced how they valued individual students. As well as the students' expression of caring for clients, the participants indicated a variety of student traits that were desirable. Two participants admitted that the physical appearance or "obnoxious" behaviours of a student can initially produce a barrier to establishing a caring relationship with a student. Other participants valued students who they perceived to be honest, intelligent, hard working, or were similar to the participants in age and life experience. Several participants stated that they shared with students the traits that they valued.

Expressing to students that they were valued and worth the time commitment of the clinical teacher were perceived as strategies for enhancing the student's self-esteem and increasing their self-confidence so that they would be more successful in their clinical experiences.

> I think I said to her that there was more to her than met the eye. Because I really felt that there was....I valued her as a student, that she was bright. That she was working hard. And that I really appreciated those things in her.

> They [the student's peers] were doing a bandaid approach, kind of covering up for her. I'll do it with you. I'll go with you. And I saw that as not getting to the real meat of what we needed to deal

> with. But I also saw those really caring peers. And the importance of building that caring in them.

Clarity of Expectations

Three participants identified the need to state clear expectations to enable students to set realistic self-expectations and to feel comfortable in the clinical setting. They believed that students who expected that they would do everything correctly sometimes experienced this expectation as an obstacle to their ability to care for clients. Two participants believed it was important to share with students the expectation that they will make mistakes as part of the learning process.

> I show them my expectations...what I expect of a new skill: to come prepared, but they are not expected to do it 100% perfect. I expect them to let me know if they are doing something they are not sure of...I try to be clear to them.

One participant was reluctant to clearly state her expectations of students. She described her teaching style as non-directive, and acknowledged that perhaps students do not always understand the "gap between what I expect and what I have conveyed" to students.

> I have gone as far as I will, in telling the student what I think she ought to do...but I am not happy with it. Its her choice. She has a license to practice. She is an adult, she has experience. I treat that the same way that I treat a colleague that is not doing the same things that I would. It would be OK. The only thing that is bugging me is the evaluative piece. Which says at the end of this I have to say how I think she did. Whereas with my colleague I'd say:

> if I were you I would have phoned. But that is as far as it would go.

Going to the Wall for Students

Caring was perceived by some participants as acting as an advocate for students, and protecting them from unfair onslaught from nurses or other health professionals. Advocacy was perceived as a means of promoting the students' trust in the clinical teacher. The participants discussed protecting students from realities they perceived to be outside of the students' control. They believed that the students should "face up" to realities that they perceived were within the students' control. In going to the wall for students, the participants' focus was on maintaining students' self-esteem.

> ...I think that I will go to the wall for my students. If there is something that is going on, if somebody tries to say something to the student, if the student is hurt by an interaction with a staff person....I will really take the students' part... I am really defensive about my students.

Caring to Confront

Participants expressed the dilemma of wanting to be caring and supportive to students, yet realizing that some issues must be confronted before they could be resolved. Several of the participants believed that students' performance difficulties often resulted from a problem of which the student either was not aware, or was trying to avoid. These situations encompassed psychological problems

such as bulimia, low self-esteem, and histories of abuse, as well as clinical performance problems arising out of lack of experience or the students' avoidance of teachers.

> Caring in a sense of caring to confront. Caring to find out what was the basis of this. It would have been easy to go through, gloss it over, and write the final evaluation that she has inappropriate verbal behaviour, she doesn't interact well with patients. And this was true. But there was a reason for it. It wasn't that she didn't have the ability. All she had ever known was she was stupid and didn't have the ability.

Experiences in caring to confront required the participants who were novices at the time of the paradigm incident to deal with their feelings of being the "bad guy". Working through these feelings enabled the participants to eventually envision confrontation as a caring strategy.

> I felt that I wanted to take her into my arms--but she wouldn't have done anything... I needed to be firm. Accept the situation. Take some action and not feel that I am being the bad guy.

Working Together

Working together was a strategy described by all of the participants. It encompassed role modelling, discussion, questioning, and exploring. The idea that the teacher and the student were exploring the issue together as co-learners was perceived by one participant as caring.

> We just walked through it step by step together. Kept in touch. I think despite the fact that I had some uncertainties about exactly what to do, I think that this was also a way of showing him that this is fairly typical of most clinical situations...to show him that uncertainty is just part of practice...it was a partnership...I would

> say: what about this...and he would say, I don't think that would work with her because...

One participant was ambivalent about the philosophy of equal partnership in teaching and learning. Although she respected the rights and values of individual students, she had not resolved her ambivalence about the idea that students were equal partners in learning:

> I don't prefer and kind of fear the kind of relationship where you are both human beings in the same boat headed in the same direction. And yet I feel that to come across as a teacher who cares, to put on an authoritarian... I am not an authoritarian kind of person. I am not.

Nursing with Students

Four participants believed that caring for students involved the teacher's active participation in the students' client care. Helping the student to give patient care was employed by these participants to develop the students' self confidence, competence, and independence.

> I tend to give them support the first few weeks. And to be there. I do hands on. I go in and work with the students. I can't stand back with my hands folded and watch the students when they need help. They are surprised when I offer to go in and help them with their patients....I find it hard to stand back and watch them flounder and not help....I've found that if you give them that help the first couple of weeks, and show them how its done, that they do become independent.

Nursing with students included role modelling and working directly with students to provide care. Integral to working with students was encouraging the student to reflect on this experience in order to develop the student's skills

and self-confidence.

> I don't know if this is right or wrong. I went in as an exemplar about relating to a client. She came along with me. Let's go in and see the client...Let's go in together and work on this together. And she got to feel comfortable with going in together. Then when I was to break her off that and she was to go in on her own, then what I did was a mock run of what we had done together and she did a mock run and we did the visualization. We went back. How did she feel when she went in with me? She felt good. So go back and consolidate that feeling. We did that a couple of times.

Nursing with students sometimes took the form of helping the student get started on an aspect of nursing care which the student feared. One participant described a young male student who was anxious about caring for a female patient for the first time. Her strategy was to be there with the student as he faced this experience:

> ...so his feeling was that he was trying to persuade me not to assign him a female patient. Of course, I assigned him a female. I said, let's go in, I want to introduce you to your patient... and I thought, let's cut through this. I said, would you show us your incision... she just pulled the blanket down and whipped her gown up over her head and said: here it is....he did very well.

Mediating Variables In The Caring Relationship

The ability to establish caring relationships with students was mediated by personal boundaries, the teacher's workload, and the teacher's role identity. The intensity of the caring relationship was determined by the definition of the teacher's personal boundaries and the student's particular need.

Personal Boundaries

Personal boundaries identified by the participants were fluid. They could be lowered if the student presented a situation of special need, or raised when the participants' lacked the necessary personal resources. Concern for students impacted on the participants' lives outside of the work environment.

> You wake up exhausted. It's just like when you are sleepless about your own life. When I am on clinical, looking after patients, I often have that feeling too. The feeling of something not completed. What else could I do? It's at you all the time. This is a profession, whether you are teaching or working, where you just don't leave it at work, close it up, and go home. There are so many emotions involved in all aspects of nursing. It is a very stressful job, as you know.

The participants acknowledged that balance in their personal lives was necessary to maintaining their availability and commitment to students. Self-care was cited by most participants as including physical and psychological care for themselves. A full life outside of the work place was seen as essential to the ability to care for students.

Workload

The participants emphasized that the realities of faculty workload and the large numbers of students enrolled in nursing education programs necessitated priorizing the time and emotional commitment offered to students.

I think it's the priorities too. The priority is

> that I am responsible for doing an evaluation, I have to write up or check off some things and hand it in. Material that I am supposed to cover. That is part of my role, I've got to attend to that. And that may mean: how are you today? What's your diagnosis? Not quite that bad.

The number of students in a clinical course was cited as a primary determinant of the participants' ability to care for individual students. The participants believed there is a need for the teacher to be available to all students. The amount of teacher time consumed by clinical practice left the participants with little opportunity to meet other demands of the work place (e.g., marking papers and preparing for classes).

> So it was more of an accident, an external requirement, not pedagogical, that there were three in that group. But it was fortuitous. Time is critical. The question is how much time does the system allow, provide for, acknowledge as necessary. And how much time do you as an individual create. Just because of your own personal values.

One participant discussed the need to recognize her own job priorities and make conscious decisions about balancing her work life:

> Knowing when an interaction with a student ...feels OK, and when it starts becoming an infringement, is an important moment to be aware of. And knowing what your personal responsibility is for how you shape your day.

Teacher Identity

Teacher as Counsellor

All participants employed counselling strategies in their teaching. They described the "fine line" between the

role of counsellor and the role of teacher as a "difficult one to walk." One participant articulated her beliefs about walking the fine line:

> If this person is in crisis and wants to talk to me right then I'm not going to say "here's the door." I'll let them talk and use good communications skills to have that person feel OK when they leave. Or if they are suicidal I would make sure that they had help. But after that initial one, then I would want them to have the kind of care they would need from someone who is in the right role to give it.

One participant described from a holistic understanding of the student as a person, the conflict between the teacher's role of assigning a low mark or failing the student and the counselling role:

> I felt placed in that position, which you always find uncomfortable, being the teacher and also seeing the need that this person might need some counselling. Some other kinds of services which she wasn't willing to go to. But she did need something. Something was interfering with her performance and she talked about it in terms of feeling depressed and feeling a lot of the symptoms of this patient.

The counsellor role was perceived by all participants as inherent in the teacher role. The participants preferred to restrict their counselling role to helping students to identify problems, listening to students, and referring students to professional counsellors.

> One major thing I learned is that it's OK to care as a clinician or as a nurse and not just as a teacher. If I had maybe let myself do that earlier that two week period might not have occurred. I gave her freedom to make the choice herself and she wasn't able to do it.

Teacher as Evaluator

> ... as a teacher you want to and need the patient to get the best care. But you need to graduate a student who is competent. And that student is a person too, who needs support and help. Where is that line? Which is more important? When you are standing right in the instructor role... the product leaving this school has to be absolutely competent.

Most of the participants discussed the dilemma of being both the teacher and the evaluator of student performance. Their conceptualization of caring relationships with students was at times in conflict with the evaluator role. The participants were unable to completely resolve this conflict.

> [Negative feedback] ...would only help to lower their self-esteem and add more stress to their lives. Whereas as a counsellor, your role is to kind of build up self-esteem. Try to encourage them to think positively. You are much more on their side in a sense, trying to help them with their lives. But as that teacher-evaluator you might be a source of additional stress. So I find that very problematic. On the one hand I could tell them the bad news, and on the other: oh, you poor thing. It is hard to do at the same time.

Many participants related a paradigm story from their beginning years as clinical teachers. These early experiences typically related to situations in which students either experienced personal problems, or identified closely with the problems experienced by their clients. These situations interfered with the students' clinical performance.

Although most participants resolved the ensuing role conflict by holding to their values as nurses, they

experienced further distress regarding their ability to objectively evaluate students once they became more involved with them. One participant described a student who she eventually realized was anorexic. This teacher described her identity conflict in the situation as one of deciding which "hat to wear":

> I was so close to this issue in my practice that I had to keep telling myself that she was not my patient, she is a student that I really care about... Because of the caring part I wanted to put another hat on and start being the clinician.

Role conflict in the evaluator role was a constant theme for most participants. This was particularly apparent in paradigms where the participant identified that a student's clinical difficulties had arisen from complex personal problems.

> And I felt really torn, because one part of me wanted to, the nursing mother part, I guess, wanted to look after her. But on the other side you have this real sense of: I have to evaluate this student and I can't "let her loose" if she doesn't know how to look after clients.

Another participant, in discussing the effects of evaluation on a student, shared this perspective of the conflict:

> What you do would only serve to lower their self-esteem and add more stress to their lives. Whereas as a counsellor, your role is to build up self esteem. Try to encourage them to think positively. You are much more on their side in a sense....but as that teacher-evaluator, you might be a source of additional stress. So I find that very problematic. On the one hand I could tell them the bad news, and on the other: oh, you poor thing. It is hard to do at the same time.

Those participants who were able to temporarily set aside the evaluator role to assume more nurturing roles remained uncertain about this role reversal until some form of affirmation of this decision occurred. Typically, the affirmation came in the form of the students' success in the program or as verbal feedback from the student up to a year after the incident.

Teacher as Authoritarian

> It doesn't work. Being a rigid authoritarian with students, and saying this is a test-- perform-- they die. And that is not going to give you any indication of what they can do.

Four participants discussed the authoritarian teacher identity. Two participants believed that the nurses in the clinical settings expected teachers to be authoritarian with their students. This lead to some conflict with the nursing staff.

> Sometimes they [nursing staff] don't acknowledge that I am doing a good job, because they don't see what I am doing... They expected me to be a gatekeeper, and an authoritarian.

The participants identified that their initial conceptualization of the teaching role as novices included the expectation that they be authoritarian in student interactions. Two of the participants reflected that, although as students they disliked authoritarian teachers, they initially assumed this identity.

> I had never been taught how to teach. All you needed to have your bachelors' degree in nursing and you may be lucky enough to have some teaching and learning courses. But essentially you taught

> how you had been taught. I remember that the teacher stands over you and evaluates how you do things. So I assumed that that's pretty much what would be expected of me.

Another participant believed that students are able to accept the authoritarian teacher. She expressed the belief that students expect teachers to be authoritarian and are confused by other teacher identities.

> ...if you take an authoritarian type of mode, they would accept that as being something as what many teachers do. That caring isn't part of being a teacher. They don't expect a teacher to be caring. I think they would be surprised actually how much the teachers do care. Or how many times you go trotting home at the end of the day and think-- what am I going to do?

Experience ultimately led the participants to reject the authoritarian role identity.

> You asked me how did I learn this? Experience, and probably negative experience with doing it the other way. Being this rigid authoritarian, I had high expectations of myself when I first started. I said to myself: they are taking these quizzes as beginning students in the lab, this was way back in my first teaching position, I said you should be able to correct these quizzes without a key. I couldn't. I don't know that basic stuff. I was stressed out for not being able to do that. So I had an expectation that, having to know all the answers, you know that classic thing. Over time you learn that is not what is really important. And maybe there are a few students who will say, you didn't know all the answers. But I can deal with that know. There are other things that I have come to value.

Teacher as Gatekeeper to the Profession

The concern that students might make an error that could harm a patient was identified as a limiting factor in the participants' ability to allow students independence in

their clinical practice. This was a marked feature of the participants' reflection on their early years as clinical teachers. Several participants acknowledged that their primary role definition as novices was as the gatekeeper to the profession. The need to prevent harm to clients and to ensure that the school produced competent practitioners caused one participant to priorize evaluation over teaching in her first year as a teacher. She described her concept of her role as:

> Protector of [the] patient. Champion of all!.. you see yourself as moulding a young nurse. I could not think that she would get it together and I'll leave her to her own. I felt this responsibility, of course, representing the school I was working for at the time, that the students would care for the patients in all respects. I had 7-8 other students so I couldn't take over for her. So I started to feel this sense of responsibility for the client.

In explaining her eventual relinquishment of the gatekeeper role, this participant discussed the difficulties of predicting which students would succeed as practitioners:

> Some of the students you hear about are excellent nurses out there. And vice-versa, you hear that someone you thought would be a real gem never went anywhere, and never practised. [some students] you thought were excellent and it never appealed to them after that. People develop in their own life despite or including what you have given them. They go through the whole program and may have started one way, but they mature and develop and by the end of the thing have sparked real interest in an area. Just go for it and flourish. I'm sure, to be honest, a lot of my instructors will be shocked to know I'm teaching. Because I really don't recall me having this great interest in going far in nursing. It all developed as I got

> more into it. I think that that's true with many. You are so young often when you are starting out that what do you know?

Shielding From Reality And Taking Over

The participants made a distinction between acts of advocacy and acts which were described as protecting the student. Although several participants believed that going to the wall for students was a form of caring, they identified as uncaring the concept of "shielding" students from unpleasant realities. This protectionism was viewed as inappropriate when a student was able to deal with a situation but the teacher's interventions had robbed the student on the opportunity to do so. The participants used terms like, "shielding", "swooping in", and "rescuing" to describe actions which "let the students off the hook" from dealing with their problems.

Many recognized that, as novice teachers, they were much more inclined to protect students. As they gained experience and insight, many participants began to feel that, although their instincts might be to protect the student, that doing so did not demonstrate respect for the student's abilities. Protecting students was determined to undermine their self-confidence, and display a lack of trust in the student.

One participant perceived protecting the student as "coddling":

> ... using the circumstances as an excuse to not expect from her what she is capable of doing... Coddling is taking responsibility for this student's behaviour even when it is something they can correct...but not

> respecting or trusting the student enough to make them accountable for what they are doing, sort of glossing over it, creating a brat who is not disciplined. Coddling in this instance would have been, you have had a really hard time, no problem, I am going to get you through this...I care about you, and I am sorry you have had a rough time, now let's deal with this.

Another participant described taking over the student's responsibilities for client care as "swooping in":

> Swooping in would have arisen out of uncertainty and anxiety and lack of confidence in the student's ability to handle it...it would have been inappropriate. It would have robbed him of the opportunity to know how competent he was. Not giving him a chance to try out his abilities.

The participants believed that students should not be shielded from the unpleasant or difficult situations which occur in clinical settings. At the same time, they did not feel that students should be left to "sink or swim" in dealing with these situations. For example, one participant described being criticized for exposing students to a clinical setting which included some violent Alzheimer's patients. The student in this paradigm had experienced living with a violent grandfather who had Alzheimer's. The student was initially "paralysed" by the clinical setting.

> We couldn't protect her from it... It was a living example. We could only care for this person for a couple of hours and we all had to take turns.

This participant's view was that students should not be shielded from this reality, but neither should they be left to cope on their own. This situation was seen by this participant as an opportunity to make visible to the students the things that nurses do to cope with difficult patients. The students were

made aware of the nurses' need to limit the amount of time they were responsible for these patients and of the support and collegial caring they offered to each other.

Summary

The participants shared paradigm cases which influenced their perceptions of caring in teacher-student interactions. The participants defined caring for students as a human trait, a moral imperative, an affect, an interpersonal interaction, and as a therapeutic intervention. Caring was identified as having a context, including the environment in which it is enacted and the culture of the school of nursing. Although caring was thought to be integral to the teacher-student relationship, the participants identified the vulnerabilities of teachers and students as caring is exhibited. Several strategies of teacher caring were identified. Integral to the selection of appropriate caring strategies is the self-esteem of the student. Mediating variables in teacher-student caring relationships were presented. It is significant that a number of differences were recognized by the participants in the way they perceived caring in nursing education as novices and their current perceptions. Novice teachers valued structure, control, and authority. More experienced teachers valued process, partnership, and collaboration in their relationships with students.

Conclusions

The reconceptualists of nursing education have called for the examination and definition of elements of caring in teacher-student relationships in nursing education (Bevis, 1991; Diekelmann, 1990; Paterson, 1991; Tanner, 1009; and Watson, 1990). This study has shed light on the perceptions of caring for students from the perspectives of nine experienced clinical nurse educators.

A brief discussion of the findings as they relate to the research questions is presented here.

1) What is the nature of clinical teachers' experiences of caring within the teacher-student relationship?

The participants experienced caring for students as complex and invisible to others. Experiences of connecting with students enabled the participants to reflect on their experience and value their role of caring for students.

2) What are the perceptions of clinical teachers experiences with caring within the teacher-student relationship?

Caring is perceived by the participants as being motivated by caring as a human trait and caring as a moral obligation. Caring is mediated by perceptions of caring as an interpersonal interaction and caring as an affect. Caring is expressed as a therapeutic intervention through a myriad of caring strategies.

3) What are the internal and external variables which influence the teachers' perspective of caring for students?

The culture of the faculty, the influences of the

behaviourist paradigm, and the lack of formal preparation for the role of teacher mediate the participants' perspectives and expressions of caring. The perceived vulnerabilities of self and students caused the participants to reflect on their decisions to care for students.

4) How do teachers perceive their role in regard to caring for students?

As novices, the participants were uncertain as to their primary role identity. They experienced conflict between their caring role as a nurse and the need to evaluate students. Paradigm stories from participants' later years as clinical teachers revealed a tendency to take risks and to priorize the students needs for support over the participants' need to evaluate student performance. The participants perceived their role to include the development of the student as a person and as a nurse.

5) How do clinical teachers express caring within the teacher-student relationship?

The paradigm stories revealed a myriad of strategies used to express caring for students and to help students to meet their goals. These expressions included a variety of counselling strategies, as well as teaching strategies to get to know students, help students to adapt to the clinical setting, and to learn from the clinical experience.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter presents a discussion of the research findings within the philosophical framework of phenomenology. This framework organizes the discussion as the central tenets of phenomenology, namely embodied consciousness, experience, perceptions, modes of awareness, and expression. The findings will be discussed regarding their application in the understanding of the lived experience of nurse educators as they care for students. The chapter will include a discussion of the implications of the findings for the preparation and continuing education of clinical teachers in nursing education. The future imperatives for nursing research are identified.

Embodied Consciousness

Social-political Antecedents

Baines (1991) contends that female dominated professions, and the work performed by these professions, is unseen and undervalued by society. The participants'

descriptions of caring from parental role analogies reflects their presumption that caring is a natural extension of the female role. However the paradigm stories and reflections of participants' more recent experiences demonstrated that caring for nursing students in clinical education is learned and not innate.

The expressions of caring by the participants were often complex, sophisticated, and difficult to decipher, particularly in the paradigm stories of the participants' recent experiences. This caring is largely unseen, undiscussed, and undervalued in nursing education (Bevis, 1989; Diekelmann, 1990; Tanner, 1990). It is imperative that nurse educators become aware of the complexity of caring expressions possessed by experienced nurse educators.

None of the participants had formal preparation for the role of clinical teacher. They learned to care for people through their experiences as human beings, parents, and nurses. The participants learned to care for students through these experiences and through trial and error as clinical teachers.

Benner (1984) asserts that experiential knowledge is embedded in the practice of nursing, and should be made visible by the study of experienced nurses. The trial and error learning of experienced educators does not have to be repeated by novice educators. This study supports the position of Bevis and Watson (1989) that nursing curriculum

development must start with faculty development.

Knowledge of the World

It appears that the participants initially approached their role as clinical teachers from the received knower stance identified by Belenky, et al. (1986). The received knower envisions knowledge as arising from others and not from themselves (Belenky et al. 1986). Most participants who shared paradigm stories from their beginning experiences as clinical teachers stated that they had difficulty defining their role as novices.

As a result of the participants' primary role definition as a teacher, the participants as novice teachers chose not to respond to students from their role definition as a nurse. They priorized their evaluative role over the role of counsellor.

It appears that for students the consequences of this initial role definition included delays in addressing students' problems and the student's withdrawal from the program. The consequences for the participants included self-recrimination, doubt, and professional growth. The paradigm situation caused the participants to reflect on their role definition, and for the most part caused them to re-define their role to include the use of their skills as nurses in their teaching.

Those participants who shared a paradigm story from

their early years as clinical teachers initially defined their role as an authoritarian. Although they cited favourite teachers who were not authoritarian, only one of the participants initially chose to emulate these potential role models. This participant assumed that her experience as a nurse defined her role as a teacher.

It is noteworthy that the participants discussed their aversion for authoritarian teachers when they were students, yet envisioned their clinical teaching role from the authoritarian stance. In assuming the authoritarian position as the expected role behaviour, the participants took on personas that were not congruent with their self-image as caregivers. The participants appeared to reject this stance within a year, and seemed bewildered about why they had ever embraced it.

The development of nurse educators requires the sharing of more than concrete strategies for teaching and evaluation of students' clinical performance. The subtleties of caring for students needs to be shared, explored, and critically examined by nurse educators. Beginning nurse educators should be encouraged to select as role models and mentors those teachers who possess a diverse repertoire of expressions of caring for students. Experienced nurse educators should share with novices their stories which illuminate the subtleties of such strategies as setting the climate, getting to know students, and making expectations

clear to students.

Past Experience

The traditions of nursing education shape the collective past experience of nurse educators. The behaviourist paradigm has been a powerful tradition in shaping the practices and processes of nursing education (Bevis & Watson, 1989). Paradigm stories from participants' early years as clinical teachers demonstrated that decisions regarding students tended to rely on concrete expectations of the curriculum. This is consistent with the findings of Paterson (1991).

The paradigm stories revealed conflict between perceived role expectations, as prescribed by the behaviourist paradigm, and the participants' conceptualization of caring for students. All but one of the teacher-as-novice paradigm stories reflected the behaviourist tenets of teacher as authority, and focusing attention on what is measurable (Diekelmann, 1990; Nelms, 1990; Paterson, 1991).

The experience of connecting with and responding to individual students enabled the participants to set aside what they perceived to be the expectations of the curriculum. However, the participants experienced conflict between what they felt was right to do, and what they perceived to be faculty expectations. Although they

expressed satisfaction with the outcomes of caring for students in their paradigm stories, the participants were hesitant to extend this ideology to students as a group.

Faculties of nursing need to make explicit their expectations of new teachers. Teachers need to explore their assumptions regarding the teacher role with an experienced mentor or through the sharing of stories with experienced teachers.

The majority of participants were ambivalent about their decisions to priorize caring for students over the objective demands of the curriculum. These participants were apprehensive regarding the quality of graduates produced in a learning environment that priorizes, values, and fosters caring. Ambivalence was not related to the number of years of clinical teaching experience.

Those participants who were able to priorize caring for students focused their attention on the needs of students and their role in promoting the growth of students as learners and as people. In responding to the needs of students, these participants expressed a belief in the students' ability to succeed in the program. They conceptualized students' shortcomings as expected and surmountable.

This response is consistent with the teacher characteristics valued by students in research of Bergman, 1990; Flagler, et al. 1988; Hughs, 1992; Miller and Haber,

1992; Mogan et al.; 1987; Nelms, 1990; Olson, 1983; and Windsor, 1987). Nurse educators need to be familiar with the results of these studies and incorporate the findings into clinical education.

The belief that the focus on what is measurable fulfils the faculty's obligation to produce competent graduates has been questioned by such researchers as Diekelmann (1990) and Paterson (1991). As they gained in experience, the participants acknowledged the limitations of their ability to predict which students will excel in their chosen profession. This is consistent with research which identifies the limitations of the behaviourist paradigm to provide secure predictions of student competency (e.g., Paterson, 1991). Outcomes of alternative nursing curricula, based on other than the behaviourist paradigm, need to be examined.

Experience

The Behaviourist Paradigm

Research investigating the lived experiences of teachers and students in nursing education has identified negative outcomes of the behaviourist paradigm. The everyday lived experience of caring for students in clinical education was revealed in the participants' paradigm stories. With the exception of the participants' beliefs

regarding shielding students, the findings of this study are consistent with previous research.

Shielding from Reality

The belief that students should not be protected from unpleasant realities was characteristic of paradigm stories from participants' later experiences. No reference to this belief was found in previous research. The findings of this study point to a need for nurse educators to become more aware of their moral decision making processes when students are faced with unpleasant realities.

The context of the students' situation determined whether participants would choose to rescue or to avoid shielding students. Rescuing and advocacy appeared to ensue from the principle of justice. Advocacy was perceived to be appropriate when the participant judged that the student had been subject to unfair or prolonged criticism from other health care workers. The decision to not shield students occurred in the context of unpleasantries inherent in patient care and when the participants judged that the student needed to confront their problems.

This seems to reflect the participants' belief that caring for students is a moral obligation based on the principle of autonomy. The participants believed that paternalistic protection of students from unpleasant realities is inappropriate. This belief contrasts with the

participants' earlier held tenet that protecting students arose from caring instincts.

Schroeder (1992) compared nursing acts which inflict pain with definitions of torture. She highlights the need to maintain presence in the nurse-patient relationship while carrying out painful nursing procedures. The usual nursing response to inflicting pain, according to Schroeder (1992), is to disembody or disassociate from the patient while inflicting harm. She calls for an exploration of more caring ways to approach this moral dilemma.

The participants in this study expressed some comfort in their role of insisting students face harsh realities. Contrary to Schroeder's (1992) claim, the participants were committed to being there with students in these situations. The participants did not perceive themselves as being alone in helping students deal with reality. The students' peers, nurses, professional counsellors, and other professionals in the clinical setting were involved in helping students deal with realities.

The Culture of the School

The culture of the faculty was described by the participants as pivotal to their ability to sustain caring for students. Roach (1991) contends that a competitive mentality in nursing is destructive and suffocates caring energy. De Tornyay (1991) claims that a caring climate of

inquiry about teaching is essential to a positive academic environment.

Some of the participants experienced a faculty culture which discouraged them from seeking advice and assistance. They felt vulnerable in approaching peers for assistance, and believed that peers lacked the time resources to discuss their problems in dealing with students. Other participants experienced a caring faculty culture in which they were able to seek assistance and advice. The participants' experiences of support or isolation were not related to the site in which they worked, but appeared to arise from connecting with one or more of their peers.

Nursing faculties need to examine the context of the work environment provided for clinical nurse educators. In the absence of formal education in clinical teaching, the support and feedback of peers appears to be a major influence on the participants' reflections and growth as clinical educators.

Participants identified that their self-evaluation of their teaching relied on formal and informal student feedback, and chance encounters with graduates. Formal mechanisms for soliciting student feedback seems to be an essential component of teacher development.

Perceptions

Morse and her colleagues (1991) examined the nursing literature on caring and developed a categorization of caring theories in nursing. The five overlapping categories they identified are: caring as a human trait, caring as a moral imperative, caring as an affect, caring as an interpersonal interaction, and caring as a therapeutic intervention. The participants identified caring from all five of these categories, suggesting that caring in nursing education cannot be defined in a simplistic model. It appears that each of the five categories contribute to the conceptualization and expression of caring in nursing education.

The Motivation to Care

The caring categories of caring as a human trait and caring as a moral imperative appeared to define the participants' motivation to care for students. The participants felt compelled to help once they were aware of students' needs. The participants selected helping strategies and made decisions about students based on these definitions of caring.

The obligation to help students meant that the participants' involvement in students' problems affected the participants lives beyond the boundaries of the educational setting. The participants described sleeplessness, worry,

and increasing their own knowledge base as consequences of caring for students. The overarching moral obligation to help also meant that the participants experienced guilt and uncertainty when they lacked the personal resources or knowledge to help students.

The participants expressed difficulty in dealing with the conflict between the moral obligation to help students and the moral obligation to produce competent graduates. This is consistent with Paterson's (1991) finding that clinical educators are required to meet the incompatible roles of coach and referee.

Mediating Variables in Caring

Caring as an interpersonal interaction and caring as an affect enabled the participants to identify the need for caring, to risk mutual vulnerability, and to individualize caring for students. Reciprocity was perceived as essential for the transmission of the caring practices of nursing. In conceptualizing caring as a mutual endeavour between the student and the teacher, the participants believed that "both parties must be communicative, trusting, respectful and committed to each other" (Morse, et al., 1991).

Expressions of Caring

Caring as a therapeutic intervention was expressed in the strategies of caring selected by participants.

Decisions regarding the selection of strategies arose out of the participants' definitions of caring as a human trait and a moral imperative. The four other categories of caring mediated the selection of strategies.

The participants' repertoire of caring strategies appeared to arise from their experiences as nurses and as clinical teachers. The paradigm stories did not illustrate caring strategies arising from knowledge of educational theory. A consequence of this lack of theoretical knowledge included such outcomes as the participants' doubting about how they went about the business of teaching and their missing cues of students' difficulties.

Modes of Awareness

Boyd (1988) describes modes of awareness, such as scientific, experiences, and perceptions, as the modes for interpreting experience and constructing meaning. None of the participants stated that they felt prepared for assuming the role of clinical teacher. They based their teaching largely on trial and error. Two participants reported changing their approach to clinical teaching as a result of a new clinical teaching model introduced in their school's curriculum. Although the clinical teaching model is research based, none of the participants reported research in nursing education which shaped their awareness of how to teach.

The study identifies a variety of strategies to express caring for students in clinical education. This suggests that nursing faculties need to make visible and valued the expertise of clinical educators who posses a repertoire of caring strategies. These faculty members should be identified and valued as role models and mentors to other faculty.

The sharing of faculty expertise could be accomplished by encouraging faculty to tell their stories about teaching. Diekelmann (1991) states that these stories reveal our expertise as teachers and make visible the how of nursing education. The valuing of this learned expertise requires a faculty commitment to the body of knowledge Carper (1978) calls aesthetic knowledge and Diekelmann (1991) calls a mode of scholarship. Only through valuing such knowledge will nurse educators risk the time, vulnerability, and commitment needed to share their stories and reveal their expertise.

In expressing caring as a therapeutic intervention, some participants valued students who expressed caring as an affect but lacked competence. Roach (1991) defines competence as essential to professional caring. The valuing of caring as an imperative in nursing education could be constrained if caring and competence are conceptualized as mutually exclusive expressions. Nurse educators need to be aware of research which identifies that patients value both expressions of caring (e.g. Watson, 1986; Larson, 1984).

Expression

The participants expressed caring for students as a myriad of counselling strategies chosen to enhance students learning and self-esteem. Kagan (1988) examined the similarities and differences in teacher-trainee and psychological counsellor-trainee research. This section examines the similarities between the participants' expressions of caring and those of the disciplines of teacher-education and counsellor in training research.

Kagan (1988) describes the roles of supervisors for counsellors-in-training as assuming three distinct roles: the teacher, the counsellor, and the consultant. The roles of teacher-trainee supervisors, according to Kagan's analysis of the research, are similar.

The teacher role is one in which the supervisor instructs, interprets events which the trainee observes, and demonstrates intervention techniques (Kagan, 1988). Control is largely held by the supervisor. The participants exhibited this role identity as teacher as authoritarian and as gatekeeper to the profession. They expressed this role as clarifying expectations, going to the wall for students, giving feedback, and role modelling.

In assuming the role of counsellor, the supervisor exerts little control over the trainee. The focus is on the trainee as a person. Activities are directed to facilitating self-growth, exploring problems, and

identifying feelings such as anxiety and defensiveness (Kagan, 1988). This is similar to the participants' role identity of teacher as counsellor. The participants expressed the counselling role through a variety of counselling strategies, valuing students, and by caring to confront students who were experiencing difficulty.

The consultant role is one in which the trainee assumes control. The focus is on the needs of clients, with the supervisor and trainee working in a peer relationship. This role was expressed by the participants as working with students and nursing with students.

Generalization of the research findings in the disciplines of psychology, education, and nursing is enhanced by similarities in the context of education in these disciplines. All work with students in one-to-one and group situations. All are influenced by bureaucratic structures and institutions such as hospitals, schools, universities, and community health settings.

The research in the discipline of psychology has identified stages of development of counsellors-in-training which may be cyclical as the learner adapts to new courses and independence of practice (Kagan, 1988). Windsor (1987) briefly describes the stages of development of nursing students. The paradigm stories did not reveal a relationship between the assumed roles of the participants and the developmental stage of the learners. Nurse

educators cannot assume without further investigation that specific role definitions or caring strategies are appropriate to any given level of student.

Implications

This study has examined the lived experience of nurse educators in caring for students in clinical education. Implications for future research have emerged from the analysis of the research findings.

1) The participants believed that the faculty culture influenced their ability to learn about teaching and to care for students. The outcomes of a caring faculty ethos has not been examined. What is the effect of a faculty cultural ethos of caring on student experiences and outcomes? Are students more satisfied with their educational experience? What is the effect on student sick days from clinical, attendance at classes, number of appeals, or number of failures? Are employers more satisfied with graduates?
2) A regression in students' clinical performance led participants to recognise students who over-identified with clients' emotional problems. The participants perceived over-identification as having a negative effect on the students' clinical performance. It is not clear from the paradigm stories how these experiences influenced the students' learning. What

are the potential learning outcomes of over-identifying with a client's problems? What caring strategies are effective and appropriate for managing students' who over-identify with client problems?

3) The participants acknowledged the role of other nurses, professional counsellors, and clients in the students' development. How do students perceive the role of other professionals and clients in their professional development? Do they have the information, access to students, and autonomy needed to effectively support student growth?

4) The study examined expressions of caring from the nurse educators perspective. The participants expressed concern that these expressions were not always perceived as caring by students. What are students' perceptions regarding the counselling strategies of probing, responding to cues, re-framing, predicting success, focusing? Do students see these strategies at all? Do they see these strategies as caring or invasive?

5) The description of the difference between the educators' role as counsellor and as teacher was described as walking a fine line. How is this fine line played out in the clinical practice setting? Participant observation of nurse educators as they walk the fine line between counsellor and teacher could shed

light on this skill.

6) The participants acknowledged that they were not always accurate in predicting which students would succeed as nurses. There is little empirical evidence to support current evaluation methods. What is the accuracy of nurse educator predictions and evaluations of which students will succeed in the profession of nursing? Retrospective study of student clinical evaluations and employer evaluations could be useful.

7) The participants in this study perceived protecting students from unpleasant realities as uncaring. What are the variables which affect a teacher's decision to not shield from reality? What strategies are employed to avoid the experience of "sink or swim" in not shielding? What do students learn from these experiences?

Summary

This chapter has addressed the major findings of the research study. Caring for students in clinical education is conceptualized from a variety of perspectives and is learned through experience as a nurse educator. It has proposed recommendations for nursing education and identified future research questions.

CHAPTER SIX

SUMMARY AND CONCLUSION

Summary

This research report presented a qualitative study of the perceptions of nine experienced nurse educators as regards to caring for students in clinical education. The study focused on the lived experiences of the participants as revealed by the research strategies of paradigm interviews and Hermeneutic analysis.

Background

The relationship between nurse educators and nursing students has largely been examined in research focusing on student clinical anxieties and anecdotal literature about clinical teaching. The predominance of students' fears in clinical education are strongly related to the behaviourist model of education which focuses on "teaching by evaluation". This has resulted in a clarion call from reconceptualists such as Bevis (1984); Diekelmann (1991); Paterson (1991); Tanner (1990); and Watson (1989) to explore and define the elements of caring in the teacher-student relationship in nursing education.

Previous research

The review of relevant literature revealed that there is a paucity of research investigating caring in nursing education. Much of the literature is anecdotal in nature, based on definitions derived from nurse-patient caring literature. Many questions concerning the nature of caring by teachers and students remain unanswered.

The behaviourist paradigm has been instrumental in shaping the practices of nursing clinical education such that evaluation is prized over learning, and objective performance over caring. This emphasis on what is easily measured has led to the undervaluing the importance of caring, and has, according to the literature, disrupted the relationships between nurse educators and nursing students.

We know that nursing students desire support from their teachers. Nursing students are asking for teacher-student relationships characterized by one-to-one interactions, dialogue, and "getting to know" each other. Diekelmann (1990) demands that we re-examine nursing clinical education. Her call to make excellence in teaching visible suggests that the exploration of the stories of excellent clinical teachers can lead to the identification of ways to reconcile the past "struggles" with students, and to explore new ways of being as teachers (Diekelmann, 1990).

Perceptions of caring for students

This report presented the participants' perceptions and expressions of caring in nursing education. It identified broad definitions of caring for students in clinical education from the perspectives of experienced nurse educators. Many strategies for expressing caring were described.

Definitions of Caring

The participants defined caring for students as a human trait, a moral imperative, an affect, an interpersonal interaction, and a therapeutic intervention. Caring was identified as having a context, including the environment in which it is enacted and the culture of the school of nursing. Although caring was thought to be integral to the teacher-student relationship, the participants identified vulnerabilities of teachers and students as caring is expressed.

Strategies of Teacher Caring

Many strategies for teacher caring were identified. These included a variety of counselling strategies, feedback, valuing, clarity of expectations, advocacy, working with students, and nursing with students. The participants perceived the self-esteem of students as integral to the selection of appropriate caring strategies. Mediating variables in teacher-student caring relationships were identified. These included personal boundaries,

workload, and the participants' primary role identity.

Learning to Care as a Teacher

A number of differences were acknowledged by the participants in the way they perceived caring in nursing education as novices and their current perceptions. Novice teachers valued structure, control, and authority. More experienced teachers valued process, partnership, and collaboration in their relationships with students.

Caring for students in clinical education was conceptualized from a variety of perspectives and was learned through experience as a nurse educator. The participants experienced caring for students as complex and invisible to others. Experiences of connecting with students enabled the participants to reflect on their experience and to value their role of caring for students.

Mediating Variables

The culture of the faculty, the influences of the behaviourist paradigm, and the lack of formal preparation for the role of teacher mediated the participants' perspectives and expressions of caring. The perceived vulnerabilities of self and students caused the participants to reflect on their decisions to care for students.

Primary Role Identity

As novices, the participants were uncertain as to their primary role identity in clinical teaching. They experienced conflict between their caring role as a nurse

and the need to evaluate students. Paradigm stories from participants' later years as clinical teachers revealed a tendency to take risks and to priorize the students needs for support over the participants' need to evaluate student performance. The participants perceived their role to include the development of the student as a person and as a nurse.

Model of Caring in Nursing Education

Caring was perceived by the participants as being motivated by caring as a human trait and caring as a moral obligation. Caring is mediated by perceptions of caring as an interpersonal interaction and caring as an affect. Caring is expressed as a therapeutic intervention through a variety of caring strategies.

Conclusion

This study has presented the findings and analysis of the paradigm cases of nine nurse educators. The study identified a number of strategies employed by nurse educators in caring for students in clinical education. The paradigm stories revealed that caring in nursing education is learned through experiences as a person and as an educator. Implications for nursing education and research were identified.

Nurse educators have little formal preparation for their role. Commitment to research, scholarly writing,

grading papers, preparing classes and fulfilling other obligations of the educator role leave little time to familiarize themselves with current research in nursing education.

Recent research in nursing education has identified negative outcomes of the behaviourist model of education. The findings of current research in nursing education must be incorporated into the processes and practices of nursing education. The findings of this research report support the premise of the reconceptualists of nursing education that the focus on evaluation of student performance can constrain the relationships of nurse educators and nursing students, and curtail student learning.

Paradigm stories from participants' more recent years as nurse educators shed light on the ability of experienced nurse educators to change their focus from the teacher-as-evaluator role to the roles of counsellor and consultant. Novice nurse educators are left to learn how to enact their roles through trial and error. The wisdom of experienced nurse educators must be shared with novices so that they can learn what these roles look like and how to enact them.

Nursing education is faced with increasing demands to graduate students who are competent in critical thinking and caring practices. The climate of caring needed to produce these graduates requires a faculty climate which supports and nurtures nurse educators. Because caring involves a

sense of vulnerability, it is essential that nurse educators feel valued and supported. A cultural ethos which values and fosters caring holds much promise in preparing future nurses who can express competence in caring.

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Appendix A:

Application of Phenomenology To Research Methods

Research Question	Dimension of Phenomen-ology	Strategy	Data Collection Methods	Data Analysis Method
nature of teacher's experience	experience	bracketing analysing intuiting describing	pre-interview paradigm interview	thematic analysis
perception of teachers	perception	bracketing analysing intuiting describing	paradigm interview	thematic analysis
role perception	modes of awareness	bracketing analysing intuiting describing	paradigm interview	thematic analysis
expression of caring	expression	bracketing analysing intuiting describing	paradigm interview	thematic analysis

Appendix B:

Research In Nursing Clinical Education

SOURCE	SAMPLE	METHODOLOGY	KEY FINDINGS
Bergman (1990)	-134 B.N. students -23 faculty -one U.S. university	questionnaire	-faculty value competence over relations with students -students value faculty interest in care, respect of student, confidence in student
Biggers et al. (1988)	171 students from A.D; diploma; & B.N. programs	state-trait anxiety scales	-high trait pleasure & high arousal-seeking tendency are associated with less anxiety
Davidzar, et al. (1985)	199 diploma students	questionnaire	-failure is attributed to external causes -success to internal causes
Diekelmann (1990)	combined studies of nursing students	hermeneutical interviews	-teachers reflect a commitment to teaching as evaluation; learning is adversarial;
Dufault (1985)	64 R.N. students in one B.N. program	quasi-experimental: 2 group pre-test, intervention, post test	-future oriented course increases internality -change could be result of teacher-student dialogue, rather than course content

SOURCE	SAMPLE	METHODOLOGY	KEY FINDINGS
Flagler, et al. (1988)	155 B.N. students at one university - 2 year period	questionnaire	-students valued: giving feedback, showing confidence in student, encouraging questions, being there for the student and not holding student responsible for seeking help -recommends teacher behaviours which encourage, promote action and discussion, provide resources for care
Hughes (1992)	10 junior B.N. students	structured qualitative interviews	caring climate: faculty acknowledge and respond to stress and anxiety; opportunities to express opinions and concerns; high priority on student needs caring through: modelling, dialogue, practice, confirmation and affirmation
Olson (1983)	450 B.N. students	questionnaire	knowledge application assisted by: individualization; verbalization; warm up period; closure

SOURCE	SAMPLE	METHODOLOGY	KEY FINDINGS
Mogan et al. (1987)	-28 university teachers -173 B.N. students in 2,3,and 4th year -7 university sites in USA and Canada	questionnaire	-teachers valued teaching skills;breadth of nursing knowledge -teachers rated as worst:lacking in nursing judgement, lacking in objectivity -students valued interpersonal skills of teacher(enthusiasm, promoting student independence, correcting without belittling) -students rated as worst: unapproachable, unclear expectations
Nelms (1990)	17 B.N. students from 3 years of the program	phenomen-ology, interviews;	-nursing ed. is a life pervasive experience; tremendous pressure and insurmountable amounts of knowledge to learn; no time for anything but studies -clinical practice the most important and meaningful -personal knowledge most valued -support of peers most useful, family and nurse support lacking -need teacher as support, expect teacher to be caring and competent -core of learning is 1:1 interactions with teachers

SOURCE	SAMPLE	METHODOLOGY	KEY FINDINGS
Lewis et al. (1987)	90 B.N. students	experimental design, questionnaire	-anxiety increases as time interval between orientation and first day increases
Miller & Haber (1992)	7 B.N. students & 7 faculty	phenomen-ology, interviews	holistic concern teacher ways of being student ways of being
Pagana (1988)	262 B.N. students	questionnaire	-threats: inadequacy making errors; uncertainty; teacher; failure
Pagana (1990)	261 B.N. students	questionnaire	-hardiness positively related to challenge scores -social support scores low -need to evaluate teacher support
Paterson (1991)	6 clinical teachers, university & diploma	ethnography: participant observation & interviews	-caring behaviours of teachers identified: listening, getting to know the student, instilling hope and vision, nurturing, accepting -uncaring behaviours: crystallization, withdrawal of helping
Windsor (1987)	9 B.N. students	phenomen-ology, interviews	-positive for learning: supportive teacher, teacher approval, -negative for learning: teacher criticism; poor relationship with teacher

Appendix C:

Examples of Caring Behaviours Derived From Categories Of Caring Theory Identified by Morse et al.(1990)

CATEGORY OF CARING THEORY	EXAMPLE CONCEPT OR BEHAVIOUR	SAMPLE SOURCE	RESEARCHER
Caring as a human trait	"being there"	-male & female patients -patients -nurses -students	Reimen(1986) Halldorsdottir (1991) Green-Hernandez(1991 Mangold(1991)
	social support	-nurses	Green-Hernandez(1991
	cared for like by a family member	-male & female patients	Reimer(1986)
Caring as a moral imperative	giving of self	-male & female patients -students	Reimer(1986) Chipman(1991)
	trust	-patients -nurses -students	Komorita(1991) (least important) Kormorita(1991 (most important) Mangold(1991) most important
	respect	-patients	Halldorsdottir (1991)
Caring as an affect	sensitivity	-nurses	Wolf(1986)
	empathetic	-patients	Green-Hernandez(1991
	supportive	-female patients	Reimer(1986)-most important
		-nurses & students	Mangold(1991)-most important
	attitudes	-male and female patients	Reimer(1986

CATEGORY OF CARING THEORY	EXAMPLE CONCEPT OR BEHAVIOUR	SAMPLE SOURCE	RESEARCHER
Caring as an interpersonal interaction	listening	-nurses -male & female patients	Wolf(1986) Reimer(1986)
	comforting	-male & female patients -nurses -patients -nurses & students -nurses	Reimer(1986) Chipman(1991) Green-Hernandez(1991 Mangold(1991) Wolf(1981),
	providing information for decision making	-nurses -nurses	Green-Hernandez (1991) Wolf (1986)
Caring as a therapeutic intervention	monitoring	-patients	Watson(1986)
	following through on observations	-patients -students	Larson(1987), Komorita(1991) Mangold(1991)
	technical competency	-patients -nurses -nurses -nurses	Larson(1984) Brown(1986) Green-Hernandez(1991 Watson(1986)

Appendix D:

Bracketed Assumptions About Caring in Nursing Clinical Education

My assumptions about caring in nursing clinical education arise from twelve years of experience, and reflection on that experience, in nursing clinical education. Reflection has been expanded by course work in the Master's of Nursing program and discussion with Professors and colleagues.

1) I now believe that many of the problems in nursing and nursing education arise from the lack of primacy of caring.

2) I also believe that the failure to recognize, and maximize the influence of the teacher's role of caring for nursing students, contributes to nursing students' difficulties in caring for patients.

3) The course in education philosophy taken in the fall of 1992, centred on the moral imperatives of education for public schools. A similar mandate exists in nursing education: in order to expect moral/ethical conduct from students, they must be nurtured in a moral/ethical community. In nursing clinical education, the clinical teacher has the moral obligation to extend the moral imperative of nursing, that is, to care, to the students.

4) I concur with Paterson (1991) that teachers care for students from their perspective of caring for patients. I believe that this is not, for many, a conscious decision. Making visible the caring of experienced clinical teachers will reveal new insights and ways of caring for students.

5) I also believe that the behaviourist paradigm in nursing education has constrained and strained nurse-educator and nursing student relationships. The power struggles which result in this paradigm are at odds with the development of caring relationships. I believe that students are capable of much more than they are able to achieve in the behaviourist paradigm. Caring for students empowers them to achieve excellence in their education and their practice.

6) Caring has been defined in many ways in nursing. I believe that there is a grain of truth in each of the definitions. I expect that an exploration of caring in nursing education will identify some concepts not currently recognized in nurse-patient caring. Once these concepts in nursing education are identified, they will likely have an influence on how we conceptualize caring in nursing.

Appendix E:

Draft of Letter to Accompany Transcripts of Paradigm Interview

Dear ____

Thank you for volunteering your time to be interviewed for my thesis, "The Lived Experience of Nurse Educators: Caring Experiences With Students in Clinical Education." Enclosed please find a copy of the transcript of our interview of _____(date). Please keep in mind that the way we talk and does not necessarily make for good reading, so do not let that bother you. What matters is your ideas. I am sending you the transcript to enable you to review it prior to our final interview together. This interview will take place _____(date) at_____ (location). The purposes of this interview are to:

1. give you an opportunity to clarify any aspect of the transcript
2. give me an opportunity to clarify aspects of the transcript
3. give you an opportunity to respond to my beginning interpretations of the interview.

I look forward to meeting with you again. If you have any questions or concerns that you would like addressed prior to our next meeting, please feel free to call me at 475-0837.

Sincerely,

Marta Crawford

Appendix F:

Description Of Study For Teachers

As part of the Master's in Nursing program, at the University of Manitoba, I am conducting a study entitled: The Lived Experience of Nurse Educators: Caring Experiences with Students in Clinical Education. The Dean of your facility, _____, has provided a list of teachers who are eligible to participate in the study, but your decision to participate or not participate in the study will not be shared with your Dean. Teachers who have at least one year of experience in clinical teaching in a baccalaureate program, and at least five years of clinical teaching experience with patients, staff or students are being approached to participate in the study.

The study will involved a telephone pre-interview to discuss your interest and questions relating to volunteering for this study. If you agree to participate, the study will consist of a two hour interview in which you will be asked to share a story about a situation in which caring for a student made a difference, and a final interview of approximately two hours to clarify questions from the first interview. If you agree to participate I will ask you for some demographic information (years of clinical teaching experience, years of experience in clinical teaching in a baccalaureate program, age and educational background).

Measures to ensure your confidentiality are as follows:

1. I will be identified by a code number on all transcripts, the thesis, publications and presentations of the study.
2. only Marta Crawford will know my identity. The list identifying me with the assigned code number will be kept in a locked drawer, available only to the researcher
3. audiotapes will transcribed by the researcher, and will not be available to anyone else. The tapes will be stored in a locked drawer, available only to the researcher
4. the identity of myself and all others discussed in the interviews (e.g., students and patients) will not be revealed in the transcriptions of the research interviews, the thesis, or in the publication or presentation of the research findings. The participants and persons mentioned in the interviews will be referred to by a code number or letter.
5. transcripts of interviews which indicate only the participant's code number, will be shared only with the researcher's thesis committee members. The thesis committee members will not be informed of the identity of the participants. The thesis committee consists of Dr. Barbara Paterson (Faculty of Nursing, Chair), who may be reached at 474-8240; Dr. Erna Schilder (Faculty of Nursing), and Dr.

Jamie Magnusson (Centre for Higher Education Research and Development). The notes and tapes will be securely stored for ten years, as recommended by the Ethical Review Committee of the University of Manitoba Faculty of Nursing.

You are free not to take part in the study. If you decide to participate in the study, you will be asked to sign two copies of a Consent Form at the first interview. One copy of the consent will be yours to keep. Your signature on such a consent indicates your willingness to participate in the study. You are free to withdraw from this study at any time even after giving your written consent. Your employment will be in no way affected by your refusal to participate in this study or withdrawal from this study. You are also free to refuse to participate in specific aspects of the study.

There may be no direct benefits to the participants in this study but there may be changes to nursing education following the completion of the study.

The researcher is currently on leave from the Health Sciences Centre, School of Nursing. The members of the thesis committee are: Dr. Barbara Paterson, Thesis Advisor; Dr. Erna Schilder, Internal Member; and Dr. Jamie Magnusson, External Member.

These committee members will not know your identity. Please feel free to contact the researcher, Marta Crawford, at 475-0837.

Appendix G:

Letter To Dean/Director

Dear _____

I am a Masters of Nursing Student at the University of Manitoba. I am writing to you to obtain permission to recruit research participants from your faculty. My thesis research is a phenomenological study of caring in teacher-student relationships in Nursing clinical education. I have applied for ethical approval from the University of Manitoba, Faculty of Nursing, Ethical Review Committee. Enclosed please find a copy of the research proposal.

I would appreciate if you could take the time to review your list of faculty members in order to list clinical nurse educators who meet the inclusion criteria of the study:

1) have a minimum of five years clinical teaching experience (with students, patients or staff). This experience includes any teaching that occurs in the proximity of a patient, in an individual or group practice setting. This includes clinical teaching in hospital and community health settings. It does not have to be experience teaching in a basic nursing program.

2) have at least one year of experience in clinical teaching in a baccalaureate program.

Once you have provided me with names and telephone numbers of eligible teachers, I will send them a copy of the Description of the Study for Teachers, and a copy of the consent form (please see Appendix F and G of the proposal) and will later contact them by phone to determine their interest in participating in the study. Their participation will consist of the telephone pre-interview, a paradigm interview of approximately two hours, and a final interview of approximately the same length. A debriefing session following completion of the study will be available to those who wish to attend.

Please feel free to contact me with any questions or concerns about the research. I can be reached at 475-0837. Thankyou for your time and consideration.

Yours sincerely,

Marta Crawford

Appendix H:

Consent Form

This is to certify that I, _____ (print full name), agree to participate in the study, The Lived Experience of Nurse Educators: Caring Experiences With Students In Clinical Teaching, conducted by Marta Crawford. This study is in partial fulfilment of the Master's of Nursing program at the University of Manitoba. The purpose of this study is to explore caring in teacher-student relationships in Nursing clinical education. I have been invited to participate because I have at least one year's experience as a clinical teacher in a Baccalaureate Nursing Program, and have at least five years of clinical teaching experience. I understand that if I do not wish to participate in this study that this will not affect my employment in any manner. If I agree to participate, I will be asked to agree to the following:

1. a brief telephone interview confirming my interest in participating and explaining the first interview.
2. a two hour interview in which I will be asked to share a story about a situation I experienced in which caring for a student made a difference.
3. I will be mailed a transcript of this interview prior to the final interview. The final interview will take approximately two hours. The final interview will give me an opportunity to clarify anything from the transcript. The researcher may ask additional questions at this interview to clarify information from my story. The researcher will share her interpretations of the story at this interview.
4. I will be given the opportunity to attend a debriefing session prior to the Thesis Oral Defense. This debriefing will give me an opportunity to respond to the research findings.

The risks of participating in this study could involve psychological discomfort that may arise from relating my story. I am free to chose the situation I wish to share. I am free to withdraw from the study at any time. My employment will not be affected in any way by taking part or not taking part in the study. Participation in the study will entail no financial costs to me. There may be no direct benefits to myself in taking part in this study. There may be benefits for Nursing education.

The procedures for maintaining confidentiality have been explained to me. These procedures are:

1. I will be identified by a code number on all transcripts, the thesis, publications and presentations of the study.
2. only Marta Crawford will know my identity. The list identifying me with the assigned code number will be kept in

a locked drawer, available only to the researcher

3. audiotapes will transcribed by the researcher, and will not be available to anyone else. The tapes will be stored in a locked drawer, available only to the researcher

4. the identity of myself and all others discussed in the interviews (e.g., students and patients) will not be revealed in the transcriptions of the research interviews, the thesis, or in the publication or presentation of the research findings. The participants and persons mentioned in the interviews will be referred to by a code number or letter.

5. transcripts of interviews which indicate only the participant's code number, will be shared only with the researcher's thesis committee members. The thesis committee members will not be informed of the identity of the participants. The thesis committee consists of Dr. Barbara Paterson (Faculty of Nursing, Chair), who may be reached at 474-8240; Dr. Erna Schilder (Faculty of Nursing), and Dr. Jamie Magnusson (Centre for Higher Education Research and Development). The researcher is currently on leave from the Health Sciences Centre, School of Nursing.

Signature of Teacher:_____ Date_____
Signature of Researcher:_____ Date:_____

Appendix I:

Sample Interview Questions And Prompts Drawn From Pilot Study

1. What does that phrase mean to you?
2. Tell me more about _____
3. So, you are saying _____ ?
4. You only need to share what you are comfortable with sharing.
5. At that point, what did you think had happened?
6. How did you feel at that point?
7. Do you want to elaborate on that?
8. So, what were your thoughts then?
9. I am curious about how that situation has perhaps changed the way you are as a teacher.
10. Are you telling me _____?

Appendix J:

Demographics

1. Years of clinical teaching experience
2. Years of clinical teaching experience in a Baccalaureate program
3. Educational preparation
4. Age
5. Description of clinical setting

Appendix K:

Telephone Pre-interview Script

Hello. I am Marta Crawford, a Master's in Nursing student at the University of Manitoba. I am calling to discuss your interest in participating in a study called the Lived Experience of Nurse Educators: Caring Experiences with Students in Clinical Education.

Did you receive a copy of the Description of the Study and Consent form?

Have you had an opportunity to read this material?

Do you have any questions about the study?

Are you interested in volunteering to participate in the study?

Anticipated questions and answers:

Purpose? Caring has been cited by many authors as the essence of nursing and a value in nurse educator-student relationships. But the concept has not been studied in nursing education. This study will examine caring in clinical education.

Why me? The Dean of your school/faculty provided me with a list of clinical teachers who have the experiential background needed for the study. The Dean will not know if you volunteer or decline to volunteer for the study.

Do I have anything to contribute?: Because you have experience in clinical teaching you have something to contribute. If you choose to participate, your story will help me to understand your perspective.

I don't know if I have a story: I believe that we all have stories which have shaped how we go about teaching. If you agree to the interview I will help you to tell your story.

I don't know which story to pick: You do not have to pick a story right now. You can think about it until our first interview. Trust that whatever story you choose will contribute to our understanding.

Can you give me a hint about what kind of story?
The main consideration is to select a story where caring made a difference. This might be a difference to the student, yourself, a patient.... It might be one where you learned something about students or clinical teaching. It might be a happy or a difficult story.

Appendix L:

Letter to Teachers

Marta Crawford

Dear _____,

I am a graduate student in the Master's of Nursing program at the University of Manitoba. I am conducting a study called The Lived Experience of Nurse Educators: Caring Experiences with Students in Clinical Education, in partial fulfilment of the Masters program. Your name was given to me by the Dean of your school/faculty as a teacher who has at least one year of experience in clinical teaching in a baccalaureate program and at least five years of clinical teaching experience with students, staff or patients. The Dean of your faculty/school will not know whether you decide to participate or not participate in this study.

Enclosed please find copies of the Description of the Study and the Consent form. These forms provide you with information about the study and the assurances of confidentiality should you choose to participate in the study. I will be contacting you by phone in the next four to seven days to ascertain your interest in participating in this study, and to answer any questions you might have.

The first ten volunteers will be selected for the study. I will notify you in writing whether or not you have been selected.

Thankyou for your time and consideration.

Sincerely,

Marta Crawford