ABSTRACT

HOFFMAN, SANDRA FLEMMING. How Nursing Students Experience Caring Relationships with Patients. (Under the direction of Dr. Carol Kasworm and Dr. Kathy Lohr).

The purpose of this narrative case study was to explore and describe nursing student experiences in the context of caring relationships with patients. Guided by Watson’s theory of human caring as a conceptual framework, the study explored the research question: How do nursing students experience caring relationships with patients?

Fifteen junior and senior students enrolled in a baccalaureate program at a major university participated in the study. Students shared stories about patient care experiences in critical incident papers and interviews. Findings suggested that how students experienced caring relationships could be reflected as stages on a continuum of learning about caring. These stages, which were interrelated and iterative, were identified as learning about oneself, learning about others, and learning to be a care provider. The stages of learning were associated with students’ advancement in their program.

Students identified factors and conditions influencing their caring relationships. These included relating to patients as unique human beings and becoming involved in patients’ illness worlds by making inquiries into how patients experienced those worlds. Other factors students identified as being related to learning about caring relationships included finding affirmation of one’s role through connections with patients, forming reciprocal relationships with patients, and developing strong interpersonal communication skills. Being respected by staff nurses, dealing successfully with difficult emotional situations in a professional manner, serving as a patient advocate, and observing caring behaviors in nurses were also identified by students as themes associated with learning to be in caring relationships.
Three conclusions relating to how students experienced caring relationships were delineated from this study. The conclusions were that caring relationships, as suggested by students, may influence perceptions of the meaningfulness and importance of the student nurse role; that caring relationships may develop as stages on a continuum of learning about caring; and that experiences in caring relationships may influence students’ perceptions of themselves as professionals.
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How Nursing Students Experience Caring Relationships with Patients

by
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DEDICATION

This dissertation is dedicated to my children, Nicole, Melissa, and Matthew, to John, and to the memory of Harriet Flemming.
BIOGRAPHY

Sandra Hoffman entered the field of nursing as a second-degree student after earning a bachelor’s degree in English. She worked in various nursing roles in pediatrics and in adult health for a number of years. After gaining this experience, she began teaching nursing students, a role she loves and continues in to this day. In the course of her teaching, Sandra became interested in knowing more about what students learned through their clinical experience that was not reflected in their formal assignments. She wondered, for example how students learned about caring. Doing this study offered her an opportunity to broaden her understandings of student clinical learning by asking students to share what it was like for them to be in caring relationships with patients.
ACKNOWLEDGMENTS

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CHAPTER ONE: INTRODUCTION

The American Nurses Association (ANA) in its social policy statement (2010) defines nursing practice by describing how nurses engage in “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” (p. 8). Nurses integrate substantive scientific knowledge about disease management, and knowledge from the humanities that emphasizes caring and advocacy to implement this practice role (American Association of Colleges of Nursing (AACN), 2010).

The American Nurses Association further explains how nursing differs from other health care professions with similar disciplinary knowledge and similar roles. This organization differentiates nursing from medicine, for example, by noting how nurses focus on the response of the individual and the family to actual or potential health problems, addressing the needs of the whole person, and not just the unique presenting health problem. “While a medical diagnosis of an illness may be fairly circumscribed, the human response to a health problem may be much more fluid and variable and may have a great effect on the individual’s ability to overcome the initial medical problem. It is often said that physicians cure, and nurses care” (ANA, n.d.). Caring and a focus on addressing the needs of the whole person are signature concepts in nursing, are integral to definitions of nursing and are a part of nursing’s framework for practice.
The centrality of caring and holistic practice in nursing are reiterated by accrediting bodies that guide nursing school curricula and standardize competencies for practice (American Association of Colleges of Nursing (AACN), n.d.; National League for Nursing, (NLN), n.d.). The powerful voice of AACN for example, in their 2008 revision of *Essentials for Baccalaureate Education for Professional Practice*, added caring as a professional value in describing the kind of basic preparation needed by a graduate nurse. Professional values -- personal beliefs about the worth of ideas in a discipline that lead to standards and thereby guide decisions about appropriate actions -- motivate nursing behavior (Fahrenwald et al., 2005).

The AACN explains the nature of caring in nursing:

Caring. . . encompasses the nurse’s empathy for, connection to, and being with the patient, as well as the ability to translate these affective characteristics into compassionate, sensitive, and patient-centered care.

Historically, nurses have provided care for patients within a context of privileged intimacy; a space into which a nurse is allowed and in partnership with the patient creates a unique, healing relationship. Through this connection, the nurse and patient work toward an understanding of a wide variety of physical, psychosocial, cultural, and spiritual needs, health-illness decisions, and life challenges (AACN, 2008, p. 27).
Background and Context

A vast body of nursing literature addresses both caring and holistic care. The concepts are interrelated. Both caring and holistic care require interacting and establishing a connection with the patient and knowing the patient as a person within a nurse-patient relationship. Each concept has a different emphasis, however. The American Association of Holistic Nurses (AHNA) has defined holistic care as “all nursing practice that has healing the whole person as its goal” (n.d.). Holistic nursing builds therapeutic partnerships with patients to strengthen human responses that facilitate the healing process. The holistic nurse recognizes the interconnectedness of body, mind, emotion, spirit, social/cultural, relationship, context, and environment. “Holistic nurses may integrate complementary/alternative modalities into clinical practice to treat people’s physiological, psychological, and spiritual needs” (AHNA, n.d.).

Caring is a necessary component of holistic nursing practice. It is a multidimensional concept that has been discussed in many different ways--as a trait, an attitude, an experience, as well as a way of being and doing, for example (Cossette, Pepin, Cote & Poulin de Courval, 2007). Caring is sometimes considered to be the “essence” of nursing. Although caring and holistic care are often considered together in the writings of nurse theorists in discussions of essentials of nursing practice (Fawcett, 1993), caring is the concept of central interest in this study. Understandings of caring can also inform understandings of holistic care.
Although the AACN incorporates caring into their lexicon as a professional value, researchers have viewed the concept in different ways, and its multidimensionality is evident in the different approaches to studying the concept that can be found in the nursing literature. Caring has been explicated as a lynchpin of the profession by humanist nurse theorists (Fawcett, 2005a). McCance, McKenna, and Boore (1997) see caring as an “essential” of the profession that requires further explication to ensure common understandings. In their concept analysis, the meaning of caring was found to include four critical attributes: “‘serious attention’, ‘providing for’, ‘concern’, and ‘getting to know the patient’,” and three antecedent conditions—‘amount of time,’ ‘respect for persons,’ and ‘an intention to care’” (p. 247). Morse, Solberg, Neander, Bottorff and Johnson (1990) in a review of the literature on caring found five different views on the meaning of caring: caring as a personal trait, as an intervention, as a moral imperative, as a characteristic of the nurse-patient relationship, and as an attitude.

While these studies illustrate differences in understandings of the meaning of caring, other studies explore caring from additional perspectives. Common themes explored in other studies include: what nurses (Glembocki & Dunn, 2010; Wilkin, 2004) and patients (Cossette et al., 2007; McCance, Slater, & McCormack, 2008) perceive as caring; how particular patient populations experience caring (Smith, 2004); strategies for teaching and how outcomes of teaching caring in nursing practice (Herbst, Swengros, & Kinney, 2010), and in nursing education (Lee-Hsieh, Kuo, & Tseng, 2005) can be designed and measured. Research has also been done to test caring theory as a guiding framework for practice, and to apply its
elements in models of practice. Some studies have focused on measurement and the development of instrumentation to identify and evaluate constructs such as caring attitudes, behavior, and processes (Andershed & Olsson, 2009).

Many studies on caring in nursing are underpinned by the theoretical work of Jean Watson, a nurse theorist who developed a theory of human caring. Subsequent to the publication of Watson’s theory in 1979, empiric studies began to emerge exploring the concepts set forth in the theory. Since Watson began her work, there has been a sustained interest in conducting research on caring and continued discussions in the nursing literature surrounding caring concepts. A recent study speaks to the relevance of research on caring and the applicability of findings to practice in healthcare today. Quinn, Ritenbaugh, Swanson, and Watson (2003), using caring theory as a theoretical framework, developed a model and guidelines for research on the impact of the healing relationship in clinical practice. The research methodologies proposed in these guidelines might help “to elucidate both the process and outcomes of healing relationships in clinical practice” (p. A65).

In Watson’s wake, other nurse theorists have also developed caring theories that serve as models of practice. Chief among them is Kristen Swanson who, influenced by the work of Jean Watson, went on to develop her own middle-range theory of caring nursing processes. The abundance of nursing inquiries about caring that followed the work of Jean Watson, and later Kristen Swanson, gives testimony to the significance and impact of this early theoretical work and to the importance given to understanding caring in nursing.
Although much of the work on caring in nursing has focused on aspects of caring in nursing research and practice, the theoretical influence of caring research is also evident in studies that explore caring in the context of nursing education. These studies focus most often on how nursing students view the meaning of caring, but have also looked at ways to incorporate caring as a concept in nursing curricula, how to teach caring in the classroom, and how to teach caring in online courses (Sumner, 2004).

Adamski, Parsons, and Hooper (2009) used learning from narratives as a methodology and examined students’ perceptions of what is meant by caring after listening to nurses share their stories of caring. Lee-Hsieh, Kuo, and Tseng (2005) taught caring through the use of a teaching tool listing caring behaviors that students could keep in their pocket and review while in the clinical setting. The authors found use of the tool had a statistically significantly positive effect, enhancing student caring behavior. One study examined how nursing students perceived the nature of caring. In this study (Kapborg & Bertero, 2003) students wrote an essay in the classroom on their image of caring. Through a content analysis, three categories were identified: doing, being, and professionalism. The students explained caring primarily as activities or as ‘doing’. They saw this aspect of care as helping patients with personal care. They also wrote about caring as part of a relationship with a patient, and saw professionalism as a part of caring that was reflected in ethical comportment. In a study of nursing students who were asked to rank the importance of caring behaviors using a caring assessment questionnaire, students were found to perceive following through on nursing tasks as the most important example of caring behavior. Developing a
trusting relationship with the patient was ranked among the least important behaviors (Ahzdemian & Vizeshfar, 2007).

Although there are a few studies that used simulation exercises as a focus for learning caring behaviors (Eggenberger, Keller, & Locsin, 2010, Panosky, 2009), in general, a common thread regarding nursing students’ perceptions of caring that is notable in most studies is how caring is understood cognitively by students. The studies do not address elements in the actual clinical experiences of students as they practice and learn caring behaviors through interactions with patients. The importance of understanding students’ experiential learning is highlighted by Benner, Sutphen, Leonard and Day (2010) who point out that a student cannot just read or hear about caring to understand what it means; he or she must experience caring by being in a relationship with a patient, in a particular nursing context.

Research Problem

Although the literature on caring in nursing is extensive, there has been minimal research that examines caring from the perspective of the nursing student. Among the studies that look at the phenomenon of caring through the eyes of students, none were found that looked at the nature of how students experience caring in clinical practice. Additionally, although the caring relationship between patient and nurse has been described as the foundation of nursing practice (Swanson, 1993; Watson, 2005), no studies were found that examined students’ lived experiences in caring relationships. A single study on caring that investigated the experience of caring from the perspective of the provider of care was found
in the literature. However, this study was done with experienced intensive care nurses. While the findings in this study do provide some insight into how nurses view the experience of being in caring relationships with patients (Wilkin, 2004), more information is needed about how nursing students experience caring relationships. Nursing students are novices with respect to learning clinical nursing practice and may have experiences that are substantively different from those of experienced nurses.

The lack of information about the realities of students’ understandings of and experiences in forming and being in caring student nurse-patient relationships is important to address in several contexts. Greater understanding of student experiences may expand the existing literature on caring by adding descriptions of what caring is like for a nursing student as he or she learns nursing practice. Through this exploration, helpful information may be gained on how students form relationships, and about contextual factors that affect those relationships. Knowledge of caring relationships from the perspective of nursing students can also provide important information about the value students ascribe to these relationships with patients and what they learn about the practice of nursing from them. Further, this information can help both educators and students understand the characteristics and importance of these relationships for the student and for the patient. The importance of caring relationships may include the impact of caring relationships on the formation of students’ attitudes and beliefs about nursing, and how these beliefs inform student behaviors (Ironside, Diekelmann, & Hirschmann, 2005).
Purpose of the Study

The concept of caring is integral to definitions of nursing practice (ANA, n.d.). Disciplinary knowledge required as preparation for practice includes an understanding of core professional values. Caring is among nursing’s core values (AACN, n.d.). Theories of caring in nursing offer a body of evidence for practicing nurses to use to ensure practice from a holistic caring framework. And while nursing education literature contains some application of theory for educators to use to prepare nursing students for a caring practice, little research speaks to the actual student experience of being in a caring relationship. More information about this aspect of nursing students’ clinical learning can provide new understandings about the formation and characteristics of caring relationships among students. The purpose of this study was to explore and describe how nursing students experienced caring relationships. It focused on gaining understandings of the contextual, lived experience of nursing students as they interacted in caring student nurse-patient relationships in their clinical experiences.

Research Question

The study focuses on characterizing student-nurse patient caring relationships. It seeks to gain understandings of contextual features of the relationships, especially of any factors that may influence the development of the relationships, and the meanings students find in the relationships. The research question that informs the study is: How do nursing students experience caring relationships with patients?
Conceptual Framework

A conceptual framework guides and explains relationships among key factors that are associated with the main phenomenon to be studied (Miles & Huberman, 1994). Jean Watson’s theory of human caring provides an important conceptual frame for this study. Jean Watson developed her theory of human caring between 1975 and 1979, a time of early development for nursing as a profession. Her theory was an “attempt to bring meaning and focus to nursing as an emerging discipline and distinct health profession that had its own unique values, knowledge, and practices, and its own ethic and mission to society” (Parker, 2006, p. 296). The theory emphasizes subjective inner healing processes within the person, as well as caring factors that are important in promoting healing. Watson developed the theory, in part, because she believed it was important to differentiate nursing’s practice role from that of medicine. Watson wanted to make nursing’s focus on caring explicit. She developed her theory to emphasize the perspective that nursing did not cure patients but rather that nurses provided holistic care that could empower patients in their recovery from illness or in their attainment of a peaceful death (Parker, 2006; Walker, 1996).

Watson’s theory situates care as the central focus of nursing and is organized around three central concepts. “Caritas,” a Latin word that means to cherish, to appreciate, to give special attention, is the foundational process in providing care (Jesse, 2010; Parker, 2006). Watson’s choice of this term was carefully considered, as her intent was to separate the concepts of care and cure, and further establish a difference between the role of nursing and the role of medicine. For Watson, curing is a medical term that refers to the elimination of
disease. In later iterations of her theory, Watson expanded and renamed the factors as *caritas* processes. Although she did not make substantive changes to their meaning, she infused the ten processes with more of a philosophical and spiritual orientation to reflect her later views on caring (Jesse, 2010).

Caring factors, a central concept for Watson, describe how the nurse is to be fully engaged in a caring practice. Watson notes ten caring factors. These factors include: 1) forming a humanistic-altruistic system of values that enables the nurse to develop a caring consciousness; 2) instilling faith and hope, which is done by the nurse being authentically present; 3) cultivating a sensitivity to oneself and to others, which refers to having spiritual practices and a transpersonal self that goes beyond the ego self; 4) developing and sustaining a helping, trusting, authentic caring relationship; 5) being present to and supportive of the expression of positive and negative feelings as a connection with deeper spirit and self and the one being cared for; 6) systematic use of a creative problem solving caring process which involves the creative use of self and all ways of knowing as part of the caring process; 7) engaging in genuine teaching-learning experience that attends to unity of being and meaning, attempting to stay within others’ frames of reference; 8) creating a healing environment at all levels (physical as well as nonphysical) that is supportive, protective and (or) corrective; 9) assisting with basic needs with an intentional caring consciousness; 10) opening and attending to spiritual-mysterious and existential dimensions of one’s own life (soul care for self and the one being cared for). The factors are important because they serve, in part, as a philosophical and moral foundation for nursing. They also serve as a core
component to guide the nurse in helping a patient attain or maintain health or achieve a peaceful death (Jesse, 2010; Fawcett, 1993; Parker, 2006). A fuller, more comprehensive discussion of the caring factors and their importance in Watson’s theory can be found in chapter two in the literature review.

A transpersonal caring relationship is also a central concept in Watson’s theory. In a transpersonal relationship, the nurse’s moral commitment, self-awareness, and a valuing of the patient’s perspective enable a connection between nurse and patient through which each can attain a higher level of self-discovery and an accompanying sense of wholeness. This union is premised on “high regard for the whole person” (Watson, 1999, p. 63). Through the nurse’s mindfulness, intentionality and genuine presence, the patient experiences caring moments within the relationship. Through caring, both patient and caregiver discover an inner power and harmony (Watson, 1979). Watson believes that “preserving human dignity, relationships, and integrity through human caring are ultimately the measures by which patients evaluate their often cure dominated experiences” (Watson, 2005, p. 51).

The caring occasion or caring moment is a third central concept in Watson’s theory of human caring. While in a transpersonal relationships, the nurse and patient come together with their unique life histories and phenomenal fields in a human-to-human transaction that Watson calls a caring occasion (Watson, 2005). In a caring occasion, the nurse seeks to recognize and connect with the inner self of another through genuine presence and by being centered in the caring moment. The nurse honors the mind-body-spirit connection in the
patient and in her own person and through caring factors, promotes self-healing (Jessee, 2010).

Watson’s theory, grounded in altruistic and humanitarian values, has broad theoretical and philosophical underpinnings, and is, at least for Watson, not only a philosophical but also a moral and ethical foundation for professional nursing. Watson’s theory bounds and provides a lens for this study in part because the theory unequivocally centers the nurse-patient relationship at the heart of nursing practice. It is also bounds the study through the concepts of caring factors and caring occasion which may help illuminate characteristics of student–patient interactions and relationships. Further, Watson’s caring theory is both about caring in a philosophical sense and caring as integral part of nursing--caring involves values and a connection with the patient through which the nurse can be a mindful and intentional helping agent. Watson’s theory of human caring offers a comprehensive framework through which student nurse-patient interactions might be viewed.

**Significance of Study**

Caring is part of a holistic approach to practice and is an expectation for the professional nurse. Theories of caring provide an orientation to caring processes and relationships and help define caring. Other understandings of caring exist in the literature, give breadth and depth to the meaning of caring, and emphasize that caring is multidimensional. Students learn to integrate the caring values of the profession into an evidence-based practice. Findings from this study may lend understanding to the nature of
the caring relationships students develop with patients that are foundational in how they learn to provide care, and have significant implications for theory, research and practice.

*Theory and Research:* Describing the meaning of caring relationships for nursing students has implications for research and theory development. Findings can extend existing research on the nature of caring relationships by reflecting qualitative understandings of what a caring relationship is like for a nursing student. Study findings can also contribute to theoretical knowledge in identifying contextual factors that influence the relationship. Salient elements in descriptions of what a caring relationship looks like to a nursing student can suggest the relative importance of individual factors that relate to caring relationships, especially those that facilitate or impede them.

*Practice:* Ironside, Diekelmann, and Hirschmann (2005) point out that nurse educators do not know how to teach students to make connections and to know patients so that students will learn how to provide care that is individualized. Iranmanesh, Axelsson, Savenstedt, and Haggstrom (2009) note that nursing education is lacking models that offer strategies on teaching interpersonal aspects of care that recognize the complexity of student nurse-patient caring relationships. Findings from this study may foster conversations among nurse educators who have an interest in identifying teaching strategies that emphasize learning caring as a part of holistic practice. Benner et al. (2010) found that the student nurse’s involvement and engagement in a relationship that leads to knowing the patient is a critical milestone in a successful journey in preparing for practice.
Findings from the study can contribute to nursing education practice by highlighting the unique knowledge of student nurses that is derived from lived experiences in caring relationships. The study also provides an opportunity for students to understand and reflect on the meaning of their relationships with patients. Through reflections on their relationships with patients, students may help define elements of a caring relationship that are most important to them in developing their practice. Additionally, helping students name what they value in relationships opens up the possibility of dialogue about caring relationships, thereby conveying to students the importance and value of these relationships.

Students’ perceptions may make students’ attitudes, beliefs and values explicit, and shed light on the meaning of behaviors that follow from them. Understanding how students think, and what they believe and value about caring relationships can help educators better understand how to positively shape clinical learning experiences. Understanding the contextual nature of caring relationships may help faculty articulate what, if anything, needs to be changed in the practice environment to support students in developing the relational and communication skills they need to keep the patient at the center of care (Ironside, Diekelmann, & Hirschmann, 2005).

In arguing for a needed transformation in nursing education, Benner et al. (2010) pointed out how different factors in today’s health care system, including economic forces, new technologies, and the nursing shortage “threaten to compromise nurses’ ability to practice state-of-the-art nursing and enact the profession’s core values of care and responsibility” (p. 9). Nurse educators have a responsibility to ensure that students develop
the necessary skills to become involved in effective interpersonal relationships with patients and families, as nurses who do not learn these skills do not go on to become expert practitioners (Benner et al., 2010). To meet this responsibility, nurse educators must understand what students describe as caring within their clinical environments in order to facilitate caring relationships.

**Summary**

Nursing education has a strong foundation for teaching from an evidence base, but less is known about how students learn the meaning of a caring holistic practice through their involvement in student nurse-patient relationships. Information from the study will help student nurses and nurse educators understand more about students’ lived experience with caring, add to the theoretical nursing education literature on this topic, and encourage educators to begin having conversations about teaching approaches that support students in developing caring as part of their framework for practice.
CHAPTER TWO: LITERATURE REVIEW

Introduction

The purpose of this study was to explore and describe how nursing students experienced caring relationships with patients. Chapter two presents an overview of literature that informs this topic. The overview includes a description of Jean Watson’s theory of human caring, which served as the conceptual framework for the study; literature on the nature of nurse caring, including studies that focused on instruments to assess and measure caring; literature on how nurses and patients perceived caring, and on how nursing students engaged in student nurse-patient relationships. It includes a discussion of work by experiential learning theorists who offer epistemological insight into the processes of clinical learning. A discussion of literature on making meaning of experience through narrative is also included.

Watson’s Theory of Human Caring

Nursing practice is guided by nursing theory. According to nurse theorists, caring is essential to a patient’s overall sense of wellbeing, emotional security, and satisfaction with care, and is a central component of nursing (Steele-Moses, Koloroutis, & Ydarraga, 2011; Swanson, 1993; Watson, 2005). How caring is implemented in nursing can be derived from theoretical models. The concept of caring as an important aspect of nursing practice is developed and made explicit in the caring theory of Jean Watson (Watson, 1979). In Watson’s theory, caring is a fundamental construct without which the practice of nursing would not be meaningful.
Watson’s theory of human caring is the conceptual framework that bounds this study. The relevance of Watson’s theory as a conceptual framework is twofold. The theory frames caring in nursing within the nurse-patient relationship, and it articulates caring processes that can guide caring practice. Other constructs of the theory--transpersonal care and caring occasions, for example--provide a theoretical lens that may illuminate how students experience caring in a relationship. Watson’s theory is about being with the patient in an everyday sense, while at times connecting more deeply with a patient through a caring occasion. It offers a framework for examining many possible caring overtones in the kinds of daily interactions students routinely experience with patients while learning clinical practice (Watson, 1997).

**Significance of the Theory**

An early nurse theorist, Watson contributed to the discipline through her groundbreaking effort to set forth a framework for nursing, and posit a philosophy to explain the discipline at a time when few other nurse writers were doing this. And, she presented nurses with a way to understand how to bring about positive changes in a person’s health through their interactions with patients. Through the concepts of inter-subjectivity and transpersonal care, she paved the way for nurses to acknowledge the spiritual side of caring and in the process, examine their own personal growth. “Overall, the orientation that undergirds the Theory of Human Caring is a relatively new way of thinking about the world in Western society” (Fawcett, 1993, p. 232). Yet, at the same time that Watson sought to establish a new perspective on the discipline of nursing, her orientation to a caring-healing
tradition harkens back to nursing’s origins first found in the work of Florence Nightingale (Fawcett, 1993).

**Origins of the Theory**

When Jean Watson began developing her theory, she believed nursing was in need of “a new structure for understanding basic nursing processes as the foundation for the science of caring” (Cohen, 1991, p. 900). Watson explained that her theory originally evolved from an attempt to create a new kind of integrated baccalaureate curriculum in which the central focus was on the caring, interpersonal relationship between patient and provider. But while trying to fashion an innovative curriculum in nursing, Watson came to believe that “components of an integrated curriculum really comprise basic core processes of nursing and that it would be more useful to develop a new structure for understanding basic nursing processes as the foundation for the science of caring” (Watson, 1979, p. 49).

Watson used her own beliefs and values as building blocks for the values and attitudes articulated in the theory. Her beliefs were likely also influenced by her experiences traveling to New Zealand, China, Thailand, India and Egypt. Influences of Eastern philosophy are apparent in Watson’s holistic and spiritual emphasis on the unity and harmony between body, mind, and soul. Yet, ironically, as Fawcett (1993) points out, to strive for unity among these concepts is to also recognize a dualism between body and mind.

As a mental health nurse with an advanced degree in counseling, Watson was influenced by the writings of psychologist and psychotherapist, Carl Rogers. A revolutionary thinker, Rogers broke with the traditional approach to psychoanalysis by promulgating the
ideals of humanistic care, and elevating the importance of the client-therapist relationship as the cornerstone of psychological care. In Rogers’ view, the patient was most importantly viewed as a person, not, as in the prevailing psychoanalytic theoretical perspective, a cluster of manifestations of a diagnosis (Smith, 2004).

The influence of Rogers’ thinking on Watson’s theory development is evident in the strong parallels between Rogers’ humanistic belief in a person-centered approach to understand personality and human relationships, and Watson’s focus on the nurse-patient relationship as the central focus of care. Rogers’ influence is also apparent in their shared belief in the innate goodness and self-actualizing potential of man, echoed in Watson’s description of transpersonal caring and the caring occasion (Smith, 2004).

Another concept underpinning Watson’s theory, also found in Rogers’ philosophy of person-centered counseling, is the idea of unconditional regard for and acceptance of the other person in the relationship. Rogers believed that the relationship between therapist and client was the cornerstone of successful therapy because it facilitated emotional and psychological healing. To be present and genuine, and to listen for the sake of really hearing the other person are themes common in the writings of both Rogers and Watson (Brown, 2007). Watson, as theorist, helped to establish unconditional positive regard as a key component in nurse-patient relationships.

Several tenets and concepts from existential phenomenologists—Heidegger, Merleau-Ponty, Kierkegaard, deChardin, and Sartre, for example—also are apparent as influences in the development of Watson’s theory of nursing. These influences include the idea that human
existence is given but what the individual makes of it is up to him, and the idea that the individual has an obligation to others. “In existential terms, the individual achieves authenticity. The authenticated person justifies himself in relation to socially constructive value choices” (Walker, 1996, p. 989). For Watson, these ideas are conceptualized in the moral imperative to care as an ideal for nursing, and in the explanation of how one is to be, by choice, intentionally in a caring relationship.

**Development of the Theory**

In 1979, in *Nursing: the Philosophy of Science and Caring*, Watson began to formalize her conceptual beliefs about nursing, maintaining that the concept of person is the central focus of the discipline. She later expanded her basic conceptual view and formalized this initial structuring of ideas into her theory of human caring in her second book, *Nursing: Human Science and Human Care* (Watson, 1979). Her work represents an effort to displace the prevailing natural and medical science perspective that looked to understand humans as bio-psychosocial beings with a less empiric, more spiritual view of nursing as a study of human science (Walker, 1996). As Watson (1997) explained much later, her first book, *Nursing: The Philosophy and Science of Caring* (Watson, 1979) was written before there was any formal movement in nursing related to nursing theory per se. It emerged from my quest to bring new meaning and dignity to the world of nursing and patient care—care that seemed too limited in its scope at the time largely defined by medicine’s paradigm and traditional bio-medical science models. I felt a dissonance between nursing’s
paradigm (yet to be defined as such) of caring-healing and health, and medicine’s paradigm of diagnosis and treatment, and concentration on disease and pathology. (p. 49)

The theory is dynamic and evolving. Watson expanded the concepts in her theory in her later books, *Postmodern Nursing and Beyond* (1999), and *Caring Science as Sacred Science*, (2005), moving more and more in these later writings toward a greater incorporation of spiritual and metaphysical elements into the theory. Yet, throughout her work, the central unifying theme is the act of caring even as the intricacies of thought in her later writings represent an attempt to inform caring with a strong metaphysical dimension.

**Essential Concepts**

Termed a descriptive theory, elements in Watson’s theory are related in that taken together they explain the meaning of caring by describing behaviors and attitudes that indicate caring, and foundational caring processes that enable one to care. In her theory, the goal of nursing is to keep the concept of care foremost for it is through caring that both patient and caregiver find meaning, and discover an inner power and harmony in transcendence (Watson, 1979). The dimensions of caring in nursing relate to the attitudes and values nurses embrace, and also to the actions that follow from these attitudes and values. And while the two main components in the theory are nursing and person, Watson sees her theory as encompassing all elements that are usually found in a nursing paradigm—nursing, person, environment, and health. However, the emphasis of the theory is on the meaning and outcome of the interpersonal process between patient and caregiver (Fawcett, 1993).
Watson describes three major concepts in her theory. These are carative factors (in her later work, she retooled these into more spiritually focused caring (caritas) processes)—a system of humanistic values important in the helping relationship as well as interventions that embody those values; the transpersonal caring relationship—the unique quality of each relationship between cared for and caregiver which has a spiritual dimension; the caring occasion—a necessary component in the act of transpersonal caring through which self-actualization for both the patient and the caregiver can occur (Cara, 2003; Fawcett, 1993).

Carative factors. Ten carative factors define foundational caring processes in Watson’s theory. Later relabeled as caritas processes, in them Watson sees a way nurses can “honor the human dimensions of nursing’s work and the inner life world and subjective experiences of the people we serve” (Watson, 1997, p. 50). The caring factors are important because their purpose is to guide the process of caring and in doing so, enable the person cared for to attain or maintain health or achieve a peaceful death. These processes include the formation of a humanistic-altruistic system of values; instillation of faith and hope; a cultivation of sensitivity to one’s self and to others; the development of a helping-trusting, human care relationship; the promotion and acceptance of the expression of positive and negative feelings; the systematic use of a creative problem-solving caring process; the promotion of transpersonal teaching and learning that considers individual learning needs and styles; the provision for a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment; assistance with gratification of human needs; and the allowance for existential-phenomenological-spiritual forces (Watson, 1979).
The first carative factor conveys the importance Watson placed on developing a strongly humanistic value system to undergird and direct professional care. According to Watson (1979), a humanistic-altruistic system of values reflects “the commitment to and satisfaction of receiving through giving” (p. 11). When the nurse subscribes to these values, the nurse has “the capacity to view humanity with love and to appreciate diversity and individuality” (Watson, 1979, p. 11). Watson believed that having a humanistic-altruistic value system was important not only in the provision of care, but for all humanity to embrace as part of a philosophy of life (Watson, 2007).

According to Watson, the second carative factor is instilling faith and hope. Instilling faith and hope applies to both medicine and nursing and reflects the importance of helping the cared for person develop faith and hope in both the treatment process and in the competence of the nurse (Fawcett, 2005a).

Recognizing self is an integral part of the caring process and of the third carative factor. It emphasizes how the development of self-awareness enables the nurse to have empathy and to truly enter into a therapeutic relationship with the care receiver. The fourth carative factor underscores this theme, too, and reiterates Watson’s belief that the helping-trusting relationship is the basic element in the provision of quality care (Fawcett, 2005a; Watson, 1979).

An extension of the previous factors, the fifth carative factor – acceptance of feelings—similarly recognizes the attitudes and values the nurse embodies when providing care, and emphasizes how therapeutic approaches include an unconditional acceptance of the
expression of both the positive and negative feelings that is a necessary part of a genuine relationship (Fawcett, 1993).

The remaining carative factors relate to nursing activities rather than to the attitudes and values that inform these activities. Factor six, for example, addresses the use of a problem solving approach to care delivery, which, for Watson, involved more than a linear use of nursing process, i.e. assessment, problem identification, planning, implementation, and evaluation. She points out that problem solving is to be creative and requires the use of self and of all ways of knowing including empirical, aesthetic, intuitive, affective, and ethical. Factors seven through nine speak to the need to implement teaching and learning with respect for individual comprehension styles; to creating and maintaining a healing environment for the physical and spiritual self; and to the need for the nurse to address patients’ physical, emotional and spiritual needs. These factors reflect how nurses are taught to practice, based on knowledge of the discipline and clinical competence. Factor ten sets forth a perspective on care that urges the nurse to consider the unique inner world of each person and the meaning each finds in her or his world, and reflects Watson’s distinct phenomenological view of the nature of experience. Watson saw the taxonomy of carative factors as hierarchical with factor ten being the most complex, and the care that was based on the factors as holistic (Watson, 1979).

**Transpersonal care.** The second major concept in Watson’s theory of caring is transpersonal care. Transpersonal care centers on helping people find meaning, discover an inner spiritual power, and experience the possibility of transcendence in the face of illness.
and suffering (Watson, 2002). Transpersonal care can bring about change in the form of self-knowledge, self-control, and self-healing and reflects Watson’s fundamental belief in the power of the human care process to produce growth and change regardless of the external health condition. Being heard and understood by another person in the transpersonal process of care can be a life-changing experience, honoring a quest for wholeness and empowering self-help. Watson depicts the nurse-patient relationship in terms of a coming together of phenomenal fields, which she calls persons’ subjective realities. Through the meeting of phenomenal fields, both the nurse and the patient are each enveloped by their respective subjective meanings, yet each is connected to the other by their perceptions of the world as experienced in the present. Genuineness and sincerity are essential qualities made manifest in the transpersonal caring process (Walker, 1996). Through transpersonal caring, nursing focuses on quality of life from the patient’s perspective (McCance, McKenna, & Boore, 1997; 2001). “. . . [T]he goal of a transpersonal caring relationship corresponds to protecting, enhancing, and preserving the person’s dignity, humanity, wholeness, and inner harmony” (Cara, 2003, p. 53).

**Human caring values.** To better elucidate the nature of the caring relationship, Watson listed what she called eleven values on which transpersonal care is built. They are what make relationships meaningful and are listed below.

1. Care and love are the most universal, the most tremendous, and the most mysterious of cosmic forces; they comprise the primal and universal psychic energy.
2. Often these needs are overlooked; or we know people need each other in loving and caring ways, but often we do not behave well toward each other. If our humanness is to survive, however, we need to become more caring and loving to nourish our humanity and evolve as a civilization and live together.

3. Since nursing is a caring profession, its ability to sustain its caring ideal and ideology in practice will affect the human development of civilization and determine nursing’s contribution to society.

4. As a beginning we have to impose our own will to care and love upon our own behavior and not on others. We have to treat ourselves with gentleness and dignity before we can respect and care for others with gentleness and dignity.

5. Nursing has always held a human-care and caring stance in regard to people with health-illness concerns.

6. Caring is the essence of nursing and the most central and unifying focus for nursing practice.

7. Human care, at the individual and group level, has received less and less emphasis in the health care delivery system.

8. Caring values of nurses and nursing have been submerged. Nursing and society are, therefore, in a critical situation today in sustaining human care ideals and a caring ideology in practice. The human care role is
threatened by increased medical technology, bureaucratic-managerial institutional constraints in a nuclear age society. At the same time there has been a proliferation of curing and radical treatment cure techniques often without regard to costs.

9. Preservation and advancement of human care as both an epistemic and clinical endeavor is a significant issue for nursing today and in the future.

10. Human care can be effectively demonstrated and practiced only interpersonally. The inter-subjective human process keeps alive a common sense of humanity; it teaches us how to be human by identifying ourselves with others, whereby the humanity of one is reflected in the other.

11. Nursing’s social, moral, and scientific contributions to humankind and society lie in its commitment to human care ideals in theory, practice, and research. (Watson, 1997, pp. 32-33)

According to Watson, the two major concepts in her theory, carative factors and transpersonal care, are linked relationally in that transpersonal care depends on the incorporation of the carative factors as foundational in the nurse-patient relationship. Watson explains transpersonal care as the actualization of the carative factors (Fawcett, 1993). The giving-receiving behaviors and responses between the nurse and patient allow each person to enter the subjective world of the other person. Transpersonal care, then, is largely art because of the way it touches another person’s soul and feels the emotion and union with another, the goal being the
movement of the person toward a higher sense of self and a greater
sense of harmony within the mind, body, and soul. (Watson, 1979, p. 71)

As Walker (1996) explains, “The two persons in a caring transaction are both in
process of being and becoming” (p. 992). The relationship has a spiritual dimension as each
person finds meaning in the discovery of self and the discovery of other. Watson also makes
it clear that through transpersonal care, the nurse is able to attain the moral ideal of care
provision (Walker, 1996).

**Caring occasion.** An important sub-component of transpersonal caring is the actual
caring occasion between the patient and the nurse. A caring occasion occurs when the nurse
and patient come together in such a way that an opportunity for caring is apparent.
According to Watson (1999), it is the moment when each person with his or her unique
phenomenal field—the person’s frame of reference —has the opportunity to decide how to
be in the relationship. The caring occasion is more than an episode in a therapeutic
relationship in which the goal is self-expression and self-actualization for the patient. Rather,
both the patient and the nurse benefit from the relationship in that the caring occasion
ultimately leads to self-discovery for both (Cohen, 1991).

If the caring occasion is transpersonal and allows for the presence
of the spirit of both people, then the event expands the human
capacities, increases the range of certain events that could occur in
space and time, now and in the future, becomes part of the life history
of both persons, and presents both with new opportunity— involves
learning from each other how to be human by identifying ourselves with others or finding their dilemmas in ourselves. (Watson, as cited in Fawcett, 2005a, p. 562)

**Critique of Watson’s Theory**

The significance and impact of Watson’s work is reflected in the extensive body of research that tests, expands, evaluates, and applies her theory. However, as Phillips (1993) points out, because there has been a proliferation of inquiries on caring related to Watson’s theory, does not necessarily mean the theory is without flaws. In four discussions evaluating Watson’s theory of human care, critics differ in emphasis, but make points in common in critiquing Watson’s theory. Among these four researchers—Cohen (1991), Jesse (2010), Philips (1993), and Sourial (1996)—comments center on Watson’s lack of clarity in her use of language and on weaknesses in how she defines some concepts.

Cohen (1991) and Sourial (1996) believe the philosophical underpinnings and theoretical definitions in the theory need to be clearer. For example, the meaning of existential and phenomenological ways of being in caring relationships is difficult to understand and needs additional explication. Cohen (1991) notes, too, that the linkages between the key concepts in the theory are vague. Carative factors, transpersonal care, and caring occasions, although interrelated, are presented as discrete concepts and the reader is expected to fill in the gaps in understanding how the concepts articulate. Jesse (2010) and Sourial (1996) also comment on the overall ambiguity in the theory due to the abstract level
of its concepts. In addition, Sourial notes, the lack of discipline in Watson’s writing style makes the concepts hard to understand.

Those who critique Watson’s theory not only point to her lack of clarity in regard to philosophical underpinnings and linkages among concepts; they also see a lack of clarity in Watson’s descriptions of the essential concepts that make up the theory. Sourial (1996) points out that although transcendence and inter-subjectivity are mentioned in the theory, their meanings are not really explained in understandable language. Sourial concludes that because of the confusing terms and unclear meaning of concepts in the theory, the theory is largely inaccessible to many nurses and its applicability to practice is compromised.

Phillips (1993) and Jesse (2010) have difficulty with Watson’s unbalanced view of nursing. They point out that by emphasizing the psychosocial aspects of nursing practice, Watson overlooks the importance of other aspects of care. For example, nurses understand how sciences such as pathophysiology and pharmacology inform care. They have extensive training in using sophisticated technology and do many activities requiring technical competence. These aspects of nursing are omitted in Watson’s theory. Jesse (2010) adds to this criticism by pointing out that Watson completely sidesteps the reality that nursing does have a disease management orientation that is an essential part of practice. She also mentions that the caring factors are not instrumental in addressing physical aspects of care (Jesse, 2010).

These authors also address additional weaknesses they see in Watson’s theory. Phillips (1993) believes Watson differentiates falsely when she uses the terms caring and
curing to distinguish nursing practice from the practice of medicine. The use of these terms mistakenly polarizes thinking about professional roles when, in fact, nurses and doctors both care and both work to cure. She also thinks Watson’s theory can never be truly applicable to practice because caring in nursing cannot be formalized through caring factors. Nursing is fluid and dynamic; no two contexts of practice are identical and no formulas for caring will fit every situation. For Phillips, there is, in fact, no reason to define nurse caring; caring is nursing and nursing is caring. To use the term caring in nursing is a tautology.

Another point made about the theory is that the carative factors are numerous and if they could be implemented, it would likely take the nurse too much time to incorporate them into practice. Further, Watson’s theory is more about being than doing, yet it does not provide explicit guidelines for how to be in an authentic transpersonal caring relationship. The nurse is left to figure out how to do this (Jesse, 2010).

Further substantive criticism comes from Sourial (1996) who notes that the outcomes of transpersonal care are discussed very little and do not have empiric support. She points out that the theory has little predictive value; that is, because the theory doesn’t describe the nature of the connection between what the nurse does as caring, and what the patient experiences as a positive response, the theory doesn’t help in determining whether or not harmony and healing will be achieved as outcomes.

Although it has identified weaknesses, Watson’s theory nevertheless provides a useful philosophical and moral orientation for the delivery of nursing care. “Watson’s theoretical concepts, such as use of self, patient-identified needs, the caring process, and the
spiritual sense of being human, may help nurses and their patients to find meaning and harmony in a period of increasing complexity” (Jesse, 2010, p. 102).

The Nature of Nurse Caring

Numerous studies on caring followed the seminal work done by Watson. Many focused on the nature of nurse caring and reflected efforts to refine definitions of the concept and create common understandings of the meaning of the concept. Although the literature defining the nature of caring is vast, this review will focus on several key threads. These threads include the work of Kristin Swanson, who, influenced by Watson’s theory, conducted research to provide empirical support for the concept of caring. Her work then led her to develop her own theory of caring. Also included are studies that establish the multidimensionality of the phenomenon of caring; studies that discuss the development of instruments intended to identify actual caring behaviors and clarify the concept through objectives measures; and studies that examine how patients and nurses perceive what caring means.

Kristin Swanson extended the work on caring begun by Watson. Swanson’s (1991, 1993) work on the nature of nurse caring focused on the need to operationalize caring by collecting practice evidence for its foundational processes. She conducted three studies to collect data to enable the articulation of caring processes as perceived by others. In her initial study, Swanson interviewed women who had miscarried to determine which caring behaviors of nurses they found most helpful. In a second study, nurses and patients were asked what caring was like from the perspective of parents’ with infants in a newborn intensive care
nursery. In a third study, mothers who received a caring intervention at the time their newborns were hospitalized, were asked to recall aspects of that experience.

The findings of these three studies cemented the concepts Swanson then used to develop into a theory of caring. Swanson’s theory involves five caring processes, which although similar to those set forth by Watson, are derived from empiric findings. Swanson’s caring processes are knowing, being with, doing for, enabling, and maintaining belief. Knowing is a striving to understand what another person’s experience of an event means; being with is understood as being emotionally open to another person’s feelings, “increasing the possibility of understanding the other person’s situation” (Andershed & Olsson, 2009, p. 599); doing for includes helpful, protective actions that provide comfort; enabling is facilitating the person transition through the unfamiliar and stressful event; maintaining belief means the care provider believes that the person will get through the event and find meaning in the future (Bailey, 2009). Like Watson, Swanson’s theory focuses on the nurse-patient relationship, and while Watson grounded her theory in altruistic and humanitarian values, Swanson’s theory is more pragmatic and relates caring to a context of transitioning through difficult events. Swanson’s work is significant in furthering the development of caring theory, and in providing empirical support for understanding the nature of nurse caring.

Other researchers, responding to a lack of consensus in the nursing literature about how to define caring in nursing, emphasized the multidimensionality of the concept. McCance, McKenna, & Boore (1997), for example, used a concept analysis methodology to
explicate the concept of caring. Following this methodology, they derived a definition of
caring that included the critical attributes of serious attention, concern, providing for, and
getting to know the patient. Critical attributes are those that must be present for caring to take
place. Other attributes were found to be antecedents to care—attributes that must be present
before the concept can be realized. These were having enough time, respecting the person,
and having an intention to care. By identifying essential elements in the concept of caring,
McCance et al. (1997) advanced understandings of the meaning of caring, and established a
definition of caring that could be used to guide future research.

Morse et al., (1990) also contributed to furthering theoretical understandings of nurse
caring. In a review of literature on the concept, these researchers explicated five perspectives
on caring. They found caring was described as a moral imperative, as a human trait, as an
affect, as an interpersonal relationship and as a therapeutic intervention. Although these
researchers saw this as an important step toward clarification of understandings of caring,
they also pointed out that their analysis emphasized how there was no one way that the
concept of caring had been used in the literature, and that there was a need for a more
specific working definition of the concept.

Other nurse writers have iterated similar understandings of caring through analyses of
the concept (Andershed & Olsson, 2009; Smith, 2004). Singleton (2009), for example, in an
essay discussing how healthcare organizations benefit by making their core ideologies
explicit, explained the importance of clarifying caring as an inherent part of nursing practice.
Singleton’s description of the concept is interesting in that it, too, reiterated elements of
caring previously identified in analyses in the nursing literature and echoed some of the ideas of Watson and Swanson. Singleton pointed out that caring “encompasses empathy, expressing concern, being astute to protect from harm or injury. It is a passion for the welfare of others….and has a component of looking to the greater good…” (p. 73).

A recent analysis of caring done by Bailey (2009) comprehensively discussed theoretical aspects of the concept by comparing the way the concept had been presented in the literature by ten nurse theorists. In a summary of findings of her comparisons, Bailey noted that although the frameworks theorists have developed to ground caring theoretically differ widely using different concepts and processes to explain caring, all frameworks define caring as a professional value or a principle for nursing action. Further, all theoretical approaches emphasize the wellbeing of the patient through the caring support of the nurse.

Measurement Instruments

One reason discussions about the nature of nurse caring continue is because caring is an aspect of practice that has traditionally been and continues to be hard to measure. In her book, *Assessing and Measuring Caring in Nursing and Health Sciences*, Watson (2009) created a compendium of major instruments designed to assess or provide an objective measure of caring. Watson comprehensively discussed these tools, explaining what aspect of caring each tool was developed to measure, and how the tool’s reliability, internal consistency, and validity were determined.

Although she compiles an extensive array of measurement instruments—22 in all--Watson pointed out that attempts to measure caring, though necessary, are challenging.
Caring is a complex subjective phenomenon. It is invisible even though it exists within a particular relationship, and it is not easily measured by objective means. Trying to reduce caring to empirical measures such as behaviors or tasks can dilute the concept making it less authentic. In spite of this dilemma, Watson makes the point that the measurement of caring is an important step to be taken in extending understandings of the concept. Measurement is a way to make caring visible in a cost conscious health system, a necessary beginning to making it possible to establish connections between nurse caring interventions and patients’ improvements in health. Such efforts represent first steps toward making caring evident, a necessary prior condition to making caring a possible indicator of quality care (Watson, 2009).

Three measurement tools discussed by Watson provide examples of instruments used in measuring an aspect of caring in nursing research. The Caring Nurse-Patient Interaction Scale (Cossette et al., 2007) is a measurement instrument intended to make caring visible by relating processes of care to outcomes of care through understandings of nurse-patient interactions. In a validation study of the tool, Cossette et al. (2007) did a factor analysis of the Scale and were able to establish construct validity for caring attitudes and behaviors in four process domains: caring as humanistic care, relational care, clinical care and comforting care.

Coates’ (1997) work using Watson’s ten carative factors in developing the Caring Efficacy Scale served to operationalize Watson’s carative factors. Using this scale, nurses rate their perceptions of their ability to express caring and develop caring relationships with
patients. Coates’ study (1997) established the content validity of the Scale suggesting that nurses perceptions of caring align with Watson’s carative factors.

Studies using a scale termed The Caring Dimensions Inventory have been reported in the literature. This Inventory, with items based on a review of literature to establish categories of caring, is a quantitative tool to measure caring behaviors. The Inventory has a 25-core item questionnaire with established reliability, internal consistency, and content validity. A study by McCance, Slater, and McCormack (2008) are among those that have validated this tool. McCance et al. (2008) also expanded the Caring Dimension Inventory by adding a similarly developed Nursing Dimensions Inventory. These two aspects of the tool were combined into a Person-Centered Nursing Index that measures nurses’ and patients’ perceptions of caring.

Caring instruments incorporate multiple aspects of caring such as caring as an indicator of quality of care, patient and nurses perceptions of caring, a ranking of caring behaviors and caring abilities, and perceptions of caring self-efficacy. Although caring may represent a phenomenon that can never truly be measured, instruments that assess and measure caring can make manifest some aspects of caring, and objective measures of caring may be a way to bridge understandings of how caring might affect health and healing. Measuring caring may be an accepted means to improve quality of care if measures can establish whether or not caring-based models of practice affect costs in addition to outcomes of care.
Nurses’ and Patients’ Perceptions of Caring

Since Watson introduced her theory of human caring in 1979, studies continue to examine its applicability to practice. Among these are studies that seek to expand understandings of caring by examining nurse caring behavior as perceived by nurses and as perceived by patients. Like studies on the nature of nurse caring, these studies have the nurse-patient relationship as their focus, and most use a measurement tool to rank the importance of characteristics of nurse caring behaviors.

The studies are important not only because they demonstrate how the use of instruments results in objective descriptions of nurses’ and patients’ perceptions of caring, but also because findings established differences between nurses’ and patients’ perceptions about what constituted caring. In the studies discussed in this review, findings indicated that nurses’ perceptions of caring centered on holistic approaches to care such as knowing the patient, listening to the patient, being with the patient, laughing and crying with the patient, and honoring the dignity of the person. Patients, however, placed more importance on the nurse knowing what to do and how to act, especially in an emergency, and viewed these examples of nurse competence as primary indicators of caring. Competencies that indicated caring as described by patients included carrying out technical activities such as starting IVs, giving treatments and medications on time, and providing good physical care (Coates, 1997; McCance et al., 2008; Papastavrou, Efstathiou, & Charalambous, 2011; Williams, 1998; Zamanzadeh, Azimzadeh, Rahmani, & Valizadeh, 2010). The different perceptions between...
nurses and patients seem to suggest that nurses do not rank instrumental dimensions of care as important examples of caring behaviors in the same way patients rank them.

In a study by McCance et al. (2008), for example, the researchers used a pretest-post-test design and an independent variable, a practice development intervention, and measured nurses’ and patients’ perceptions following the intervention using a Patient Centered Nursing Inventory. This Inventory is the same as the Caring Dimensions Inventory but with a Nursing Dimensions Inventory added to it. Items on both inventories were derived from Watson carative factors. The study demonstrated incongruence between nurses’ and patients’ perceptions of caring. Nurses perceived caring to be listening to the patient, explaining procedures, and being with a patient during a procedure. Patients saw only one of these behaviors as important—listening to patients. Other behaviors important to patients included providing privacy and assisting with a personal need.

In contrast to the findings of McCance et al. (2008), Williams (1998) found similarities were greater than differences between nurses’ and patients’ perceptions of caring. In examining perceptions of caring among oncology patients, Williams found patients perceived caring expressed through nurses’ affective behaviors and attitudes to be just as important as nurses’ technical activities. Nurses’ interpersonal skills were valued most as patients ranked being recognized as a unique individual, being listened to, and being able to share feelings and be accepted as the most important aspects of their nursing care.

Zamanzadeh et al., (2010), in a study comparing nurses’ and patients’ perceptions of caring on an oncology unit, found some differences in perceptions of caring between the two
groups. A convenience sample of over 200 patients ranked caring behaviors using a Caring Assessment Questionnaire. This questionnaire contained the following six subscales of caring—being accessible, explaining and facilitating care, comforting, anticipating, creating a trusting relationship, and monitoring and following through, and used a Likert Scale format for rating caring behaviors. Interestingly, in this study both patients and nurses ranked instrumental aspects of care as most important, with monitoring and following through receiving the highest ranking from both. This category included items such as giving medications and treatments on time, and knowing how to give shots and start IVs. However, nurses more than patients valued monitoring and following through on care, while patients more than nurses saw accessibility and provision of comfort measures as more important. Patients also gave higher ranking than nurses to receiving explanatory information. However, none of these differences were significant. Both nurses and patients perceived behaviors that indicated professional competence as more importance than interpersonal skills.

In summarizing the literature on differences between patients and nurses perceptions of caring behavior, Papastavrou et al., (2011) found that in many of the review studies, patients and nurses had divergent views on what constitutes caring. Patients appeared to view the instrumental, technical activities of nurses as reflecting nurse competence and as more important caring behaviors than nurses’ affective or expressive caring behaviors. The study by Papastravrou et al. adds additional evidence that nurses and patients perceptions of what constitutes caring do not always coincide.
Summary of the Nature of Nurse Caring

While research on the meaning of caring will no doubt continue to be done, it is clear that there is some agreement about the phenomenon of human caring in existing empirical evidence. It is a complex phenomenon and a core construct in many nursing theories. It is often considered an essential characteristic of nursing practice. It is a universal phenomenon yet may be expressed in different ways. Processes of caring, for example, may be configured differently, as well as what are considered caring attitudes and behaviors. These expressions and understandings of caring may vary among cultures (Clarke et al., 2009). According to Watson and Swanson, and those influenced by these theories, however, caring can only be expressed interpersonally in the nurse-patient relationship, which forms the basis for a caring practice (Smith, 2004). Instruments to measure caring provide a more comprehensive picture of the multidimensionality of the concept (Cossette et al., 2007; McCance et al., 2008), and may provide a means to further refine how the concept can be studied, and how findings can be communicated in future research and in practice.

Further, there is not always agreement between nurses’ and patients’ perceptions of what caring means, and nurses cannot assume that their intentional caring behaviors are seen in the same way by patients. Differences in perceptions of caring between nurses and patients may mean that patients’ needs go unmet. Nurses must understand the patient’s perceptions of care and communicate with patients in ways that ensure the patients’ caring needs are understood and addressed. Differences between nurses’ and patients’ perceptions of nurse caring may be because nurses do not view their competence and abilities to implement
technical skill as caring behaviors or activities, but instead take this part of their practice for granted. Differences may also be related to the differences in the care needs of patient population studied. Also, some studies on nurse and patient perceptions of caring were done in different cultures and these different contexts could influence how patients view caring behaviors.

**Nursing Students in Relationships with Patients**

Because the purpose of this study was to explore and describe how nursing students experienced caring relationships with patients, understandings about how nurses and students form relationships with patients and engage in interpersonal processes within relationships can be helpful. Knowing about the nature of nurse and student nurse-patient relationships may add insight into conditions or factors that influenced the relationships and perceptions of relationships as caring.

In examining nurse-patient relationships as part of a factor analysis of the Nurse-Patient Interaction Scale, Cossette et al. (2005) provided insight into how caring elements in a relationship can be characterized. The factors on the Scale paralleled carative factors in Watson’s theory, and confirmed that caring included “deliberate thoughts, feelings and actions directed at understanding the client and his or her needs; assistance to clients in finding meaning and hope in their health-related experiences; and inter-subjective presence and dialogue to allow clients to learn and develop” (p. 675). The nurses in this study echoed Watson’s descriptions of intentionality as a part of caring as they described entering
relationships with an intention to develop and maintain a trusting, authentic caring relationship that facilitated health and healing.

Empathy, an important aspect of caring, was studied by Ramvi (2011). She noted that interacting and communicating with patients was one of the hardest tasks for nursing students. In her study, she found the levels of tension and anxiety among nurses on the unit where the students had their clinical experience affected student communication with patients and their feelings of empathy. Although students believed that creating a relationship with a patient was important, they were influenced by the stress levels of the nurses, and found it easy to lose their focus on the relational aspect of their work. Instead, they found themselves drawn into an instrumental style of nursing.

In another study (Ketola & Stein, 2013), however, findings indicated that during a psychiatric nursing experience, students reported learning to communicate with patients, even though some said they were initially frightened about the prospect of interacting with patients who were emotionally distressed. Students’ fears were mitigated as they began to see patients as individuals. They developed relational and communication skills that included a sense of self-awareness, reflection, and empathy. Another study had similar findings (Idczak, 2007). First year nursing students in the Idczak study illustrated five themes in journals they kept about their clinical experiences. Among these themes was fear of interacting with patients. But also among the themes were developing confidence, becoming self-aware, connecting with knowledge, and connecting with patients.
Communication skills are fundamental in student nurse-patient relationships. As novices, nursing students learn to be in relationships with patients by first learning patient-centered communication. Although students are taught the purpose and characteristics of therapeutic communication in the classroom, a number of authors have pointed out that beginning nursing students may not yet have the skill set to experience the nurse-patient relationship in the same way as an experienced nurse. Orland-Barak and Wilhelem (2005), for example, found that, “student nurses’ stories of learning to become a nurse in practice settings, are characterized by procedural language, by medical rather than nursing terminology, and by a focus on actions rather than on interactions” (p. 455). Similarly, Suikkaly, Leino-Kilpi, and Katajisto (2008) using questionnaires developed for their study, found that although nursing students viewed the nurse-patient relationships they developed as facilitative, patients regarded the relationship as more mechanistic, that is, as focused on the students’ learning needs rather than on the patients’ needs. Facilitative relationships, in contrast to mechanistic relationships, are characterized by mutuality, and a focus on the common good of both student and patient; they are directed by patient’s wishes and are ones in which student and patient know each other personally and have conversations that include what the patient is feeling and experiencing. In a facilitative relationship, the patient is regarded as an expert on his or her own situation.

Two studies on patient-centered therapeutic communication, however, describe the formation of student-nurse patient relationships using effective communications skills. These studies point to the benefits of this kind of communication to student learning and in
positively influencing patient care experiences. In one study Puentes (2000) described an exercise in which students were paired and formed relationships with the same patients in a long term care setting over the course of one semester. They were given a listening assignment that included the use of social reminiscence with the older adults. Through social reminiscence, patients reconstructed meaningful events from their past and shared their histories with the students. The students benefited from the assignment by developing respect, empathy, and an understanding of the past lives of the older adults with whom they were paired. And, they learned to communicate therapeutically with patients.

In the second study, Hayes (2005) also found students and patients benefited in similar ways when students learned the therapeutic use of self during a clinical experience caring for hospice patients receiving palliative care. Students visited hospice patients weekly as part of a mental health course. Goals for the experience were for students to learn to communicate effectively and compassionately with their patients, demonstrate respect for the patients’ end-of-life care wishes, and assist the patients and families to cope with suffering, grief, loss, and bereavement. It was expected that students would also become aware of their own attitudes toward death and dying through this experience. Students wrote about their experiences in journals. Journal reflections pointed to students learning therapeutic use of self, empathy, and gaining insight into experiences surrounding death and dying. One student commented, “it helped me to realize that patients are more than just their illness” (p. 87).

Learning to be effective in a student-patient relationship is the single most important nursing function that supports students’ professional growth (Granum, 2004; O’Connor,
Trinh, & Shewchuk, 2000). Through their interactions with patients, students learn their own personal strengths and limitations, how to view situations from the patient’s point of view, and how to provide care that considers the patient as a partner in planning care (Suikkala et al., 2008). In part, students’ struggles to gain a perspective that foregrounds the student-patient relationship and places less importance on performing technical skills is part of the natural progression of learning the professional role. Although they have rehearsed interpersonal skills while in the classroom, when in the clinical setting, students also have to “learn to manage strong feelings and adopt a professional approach to their patients while developing personal relationships with patients” (Suikkala et al., 2008, p. 540). Over time, however, “students adopt a person perspective and move away from being mechanistic, closely focused on tasks, toward being present with patients as persons and seeing and responding to their unique characteristics and needs” (p. 2).

**Learning in Contexts**

Nursing students learn nursing practice through experiences knowing their patients in individual patient contexts. There are many dimensions to understanding experiential learning. The views presented in this review emphasize the contextual nature of learning. Basic views on how experience happens narratively and can be understood through narratives are included (Clandinin and Connelly, 2000). The interconnectedness of narrative and understanding experience illustrates how learning professional practice cannot be understood through empirical methods alone (Webster & Mertova, 2007).
Experiential Learning

Schon, Polanyi, and Heron are learning theorists whose writings are important in establishing how the nature of experiential learning is contextual rather than theoretical (Connelly & Clandinin, 1986). Writers such as John Dewey, Kurt Lewin, Jean Piaget, Paulo Freire and David Kolb, termed reflection-on-action theorists by Merriam and Caffarella (1999), viewed the learner as someone who can step outside of an experience to reflect, analyze, and learn from the reflection, and then integrate that learning into earlier learning. Their writings posit that theoretical knowledge can be applied as practical knowledge in practice situations. Schon (1995), Polanyi (1967), and Heron (1999), however, see learning as embedded in practice, occurring in a particular context, with reflection being an integral part of learning. This learning process has been called reflection-in-action.

Reflection-in-action writers envision learning as reframing events or experiences and finding new ways to respond to them. For these thinkers, reflection is not analysis because past and current experiences cannot be separated. When the reflection-in-action view underscores professional practice education, the concepts of practical and tacit knowledge become important (Merriam & Caffarella, 1999). Because reflection-in-action writers’ understandings of professional practice focused on learning in the practice environment itself, they established a framework for more contextual understandings of how professionals learn to practice.

Reflection-in-action/tacit knowledge. Those who see learning from experience as reflection-in-action are concerned with reflection as an integral part of learning on-the-spot,
learning that encompasses reframing an event or experience and finding new ways to respond to it (Merriam & Caffarella, 1999). Boud and Walker (1990) illustrate this concept by pointing out that experience and reflection are intertwined, in contrast to Kolb’s view that reflection involves analysis of an experience, for example.

Schon (1995) describes how experience and reflection are intertwined as he describes the concept of tacit knowing in the context of professional practice.

When we go about the spontaneous, intuitive performance of the actions of everyday life, we show ourselves to be knowledgeable in a special way. Often we cannot say what we know. When we try to describe it, we find we are at a loss, or we produce descriptions that are obviously inappropriate. Our knowing is ordinarily tacit, implicit in our patterns of action and in our feel for the stuff with which we are dealing. It seems right to say that our knowledge is in our action. And similarly, the workaday life of the professional practitioner reveals, in its recognitions, judgments, and skills, a pattern of tacit knowing-in-action. (p. 34)

Knowing is embedded in competent practice. Reflection-in-action in the practice setting entails “the practitioner’s generation of actionable knowledge in the form of models or prototypes that can be carried over, by reflective transfer, to new practice situations” (Schon, 1995, p. 34). Schon (1995) further explains how tacit knowing is an implicit component in how reflection-in-action happens.

The process of reflection-in-action begins when a spontaneous performance—
such as riding a bicycle, playing a piece of music, interviewing a patient, or teaching a lesson—is interrupted by surprise. Surprise triggers reflection directed both to the surprising outcome and to the knowing-in-action that led to it. It is as though the performer asked himself, ‘What is this?’ and at the same time, ‘What understandings and strategies of mine have led me to produce this?’ The performer restructures his understanding of the situation—his framing of the problem he has been trying to solve, his picture of what is going on, or the strategy of action he has been employing. On the basis of this restructuring, he invents a new strategy of action and tries out the new action he has invented, running an on-the-spot experiment whose results he interprets, in turn, as a "solution," an outcome on the whole satisfactory, or else as a new surprise that calls for a new round of reflection and experiment. This is the sort of thing a physician may do when encountering a patient whose particular configuration of symptoms is ‘not in the book.’ It is what a good teacher does as she tries to make sense of a pupil's puzzling question, seeking to discover, in the midst of a classroom discussion, just how that pupil understands the problem at hand. (p. 34)

Tacit knowledge, then, is personal and contextual, and is embedded in an individual’s action, influenced by past experience, and informed by values and ideals. Used in cognitive apprenticeships to teach professional practice, tacit knowing encompasses the concept of
“know-how”, which can be shared only informally through interactions, observation and participation. According to Polanyi (1967), tacit knowing can become formal knowledge. To explain how tacit knowing becomes formal knowledge, he uses an example of how a blind man uses his cane as a “probe” – a tool that touches things—and through it finds meaning in how to navigate. For Polany, individual learning involves experience, reflection-in-action, and a final construction in which “we know more than we can tell” (p. 4). Tacit knowledge can be transmitted using metaphor and analogy to share individual personal knowledge (Wasonga & Murphy, 2006).

Writers like Dewey, Kolb, Piaget, and Boud all see experiential learning and reflection on learning as primarily cognitive, individually focused, and occurring in discrete steps. Yorks and Kasl (2002) ask educators to examine the assumptions about what it means to learn from experience, saying that the above mentioned writers represent a pragmatism perspective on learning that is not holistic, relies on cognition and analysis to create meaning, and conceptualizes experience as a kind of entity, something out there. “Among North American, and especially U.S. adult educators [Dewey, Kolb, Boud, Schon, for example], experience has been conceptualized as a noun, a resource that can be catalogued, objectified, and reflected on” (Yorks & Kasl, 2002, p. 180).

**Heron and whole person learning.** The nature of contextual learning is also illuminated in the work of John Heron. Heron (1999) linked learning and lived experience but his conceptualization of how this happens is very different from the reflection-oriented constructivists. John Heron ushers in a perspective that explains learning from a
phenomenological view that incorporates the whole person and multiple ways of knowing. His perspective offers a view of practice learning that, like Schon’s, situates learning as occurring in practice.

According to Heron, (1999) learning has four interdependent forms, which complement and support each other.

- Practical learning – learning how to do something -- involves acquisition of a skill and the theoretical underpinnings that inform how to do the skill.
- Conceptual learning – learning about a subject – is learning that something is the case. Conceptual learning is expressed in statements and propositions. It is intellectual, verbal-conceptual.
- Imaginal learning – learning configurations of form and process -- involves an intuitive grasp of a whole as shape or sequence. “It is expressed in the symbolism of line, shape, colour, proportion, succession, sound, rhythm, movement” (p. 2). It can be metaphorical, evocative and narrative use of language as found in poetry or novels and drama. Heron calls this presentational knowing.
- Experiential learning is learning by encounter, by entering into a state of being. “It is manifest through the process of being there, face-to-face, with the person, at the event, in the experience. This is the feeling, resonance level of learning” (Heron, 1999, p. 3).
The forms of learning inform, support and enhance each other. Heron presents these aspects of learning as belonging in an “up-hierarchy” beginning with experiential learning at the base, and moving upward through imaginal, conceptual, and then practical learning. Those modes higher in the list are grounded in those that are lower. Experiential learning refers to the whole hierarchy, but experiential knowing is the foundation of all other forms of knowing. The four forms can also be thought of as a cycle leading to enriched experiential learning. Each kind of learning represents a different epistemology.

Heron differs from other constructivists in his emphasis on how one learns from experience. He points out that to interpret feelings, presences and images with words and then assume that it is the interpretation that is important is to miss the point of experience as an encounter. Yorks and Kasl (2002) illustrate affect’s relationship to learning in Heron’s view by pointing out three key points: the nature of experience is a felt encounter; multiple ways of knowing are present with each being important and balanced and having its own “canon of validity” (p. 182); and there is a distinction between feeling and emotion.

For Heron, learning is a process of self-development and the person’s developmental challenge is to become good at “critical subjectivity” – an awareness of the four modes of knowing, “—of how they are….interacting, and of ways of changing the relations between them so that they articulate a reality that is unclouded by a restrictive and ill-disciplined subjectivity” (Heron & Reason, 1997, p. 281). Critical subjectivity is a validity procedure that refers to the ability of people to think objectively about their beliefs and theories and thereby improve the reliability of their claims to knowing the nature of their own
experiences. It means that people can depend on their knowledge of lived experience and develop and build on it—it means “that we do not have to throw away our living knowledge in the search for objectivity” (Reason, 1999, p. 210). Critical subjectivity is important for it refers to how an individual manages congruence among ways of knowing.

Heron’s (1999) writing speaks to whole-person learning that includes feeling as a part of a person’s capacity to “become at one with the content of experience, and at the same time know….distinctness from it. …Feeling is a necessary condition of ordinary perception” (p. 45). What is unique in Heron’s theory of whole-person learning is not so much that the affective mode is an integral part of learning, but that affective and cognitive dimensions are not presented as separate and distinct from one another.

Paradigmatic and Narrative Knowing

Some of the earliest work on narrative knowing is found in the writings of Jerome Bruner (2006). In exploring ways of knowing, Bruner divided forms of cognition into two discrete kinds of thought that individuals use to meet different cognitive needs for different purposes in different contexts. For Bruner, these two forms of cognition are not interdependent and are not hierarchical. Each is essential in making meaning from experience by constructing a comprehensive sense of reality.

Each provides a way of ordering experience, of constructing reality, and the two (though amenable to complementary use) are irreducible to one another. Each also provides ways of organizing representation in memory and of filtering the perceptual world. Efforts to reduce one mode to the
other or to ignore one at the expense of the other inevitably fail to capture the rich ways in which people ‘know’ and describe events around them.

(Bruner, 2006, p. 116)

Bruner (1986) characterizes these two modes of thought as paradigmatic or logico-scientific knowing, and as narrative knowing. The modes differ in how each establishes truth. The paradigmatic mode encompasses the use of logical propositions. It is the language of mathematics, science, and logic. It uses established procedures, often the scientific method wherein hypotheses are tested, to ensure verifiable evidence and to test for empirical truth.

Grounded in positivism, it is the one we understand best because it has been around for a long time and is the foundation for our thinking about how the universe is ordered. Paradigmatic thinking not only depends on formal verification procedures to test for empirical truth, but also, eventually, for theory development. “The imaginative application of the paradigmatic mode leads to good theory, tight analysis, logical proof, and empirical discovery guided by reasoned hypothesis” (Bruner, 2006, p.117). Truth, according to this mode, “is a clear matter that depends upon tests in some possible world to determine whether an explanation captures the relevant facts…” (Bruner, 2006, p. 117).

Whereas the paradigmatic mode leads to verifiable phenomenon, application of the narrative mode leads to good stories. Although elements in stories may be verifiable, the stories themselves don’t represent truth but rather a way to make meaning from experience. Narrative knowing has a number of dimensions—it is bound by time, has an action component but also a component of consciousness where those involved in the action know,
think, and feel. Unlike science, narrative is said to be value-laden; it is concerned with explaining human intention in the context of action. Importantly, according to Bruner (2006), “…the two strategies [of knowing] are not only different but are drawn from two fundamentally different modes of putting together knowledge” (p. 126).

Polkinghorne (1988) also discusses the differences in paradigmatic and narrative modes of thought, how they yield different kinds of knowing, and why understanding narrative is so important from the perspective of the practitioner. His work adds to that of Bruner, and his thought marks an important turning point in connecting narratives to practice. Polkinghorne (1988) points out that patients use narratives to tell their signs and symptoms; “the narrative scheme serves as a lens through which the apparently independent and disconnected elements of existence are seen as related parts of a whole” (p. 36). Because our ability to make meaning of experience depends on narrative, practitioners depend on the interview as a way to elicit patient stories in which the patient’s narrative construction, rather than a true description of actual past events, may be most important. Polkinghorne (1988) gives an example from Mishler, who discusses how an interview can provide not only answers to an interviewer’s questions but also the patient’s story.

….Interviewers seeking merely short answers from respondents often receive long, storied responses. Because the story frequently is a digression from the answer sought by survey interviewers, only the portions of the response considered relevant are usually recorded.

According to Mishler (1986), ‘There is a cumulative suppression of stories
through the several stages of a typical study: interviewers cut off accounts that might develop into stories, they do not record them when they appear, and analysts either discard them as too difficult to interpret or select pieces that will fit their coding systems.’ Narratives are a recurrent and prominent feature of accounts offered in all types of interviews. If respondents are allowed to continue in their own way until they indicate that they have completed their answers, they are likely to relate stories. (p. 163)

**Ways of Knowing in Nursing**

Although expectations for nursing students’ clinical learning, and the measurement of that learning are generally defined within a positivist perspective, the kind of learning students encounter when working with patients is contextual and situated in individual patient cases. Concepts nurses apply in practice encompass care, empathy, presence, ethics, advocacy, and spirituality, for example—concepts less amenable to being understood through a positivist lens. The kind of knowledge reflected in these concepts is what Carper (1978) calls personal knowledge. These concepts, which form a meaningful part of practice, also help make explicit the holistic nature of nursing. Further, these concepts can only be actualized through participation in a nurse-patient relationship.

Newman and Jones (2007) discuss the need to recognize that we are embedded in what we want to study, and cannot step outside the process. For them, as well as for nursing students, the nature of nursing must be understood as a “dynamic, relational process”--one that recognizes that “the nature of reality is not outside ourselves” (p. 122). This way of
knowing requires the nurse to move away from the observer role, and participate in a mutual process of interaction with the patient, or, according to Chinn (2007), take on the philosophical perspective of knowledge development as process rather than as problem-solving. These admonitions to recognize how knowledge can be constructed are echoed in Schon’s (1995) proposal that “perhaps there is an epistemology of practice…where kinds of knowing are already embedded in practice through knowledge generation—not that the results of research (evidence) are applied in a static state” (p. 29).

Knowing the patient. Benner and Diekelmann (1993) point out that expert nursing depends on integrating not only objective facts about patients, such as specific information about diagnoses, their social and family histories, ways of coping with and managing their illness, but also on knowing the patient in other not solely cognitive ways. It is the kind of knowing that describes how nurses can grasp the meaning of a situation for the patient, or recognize the need for a particular action. Without this kind of knowledge about the patient, nurses are less able to make skilled clinical judgments, be as involved in patient care, and less able to advocate for their patients’ needs. In short, knowing the patient as a person is as important as understanding the patient’s clinical presentation if one is to give expert care.

Even though nurses describe knowing the patient as central to skilled clinical judgment, nurse educators may have difficulty teaching students ways to do this because an established methodology for this kind of teaching is lacking, and the importance of gaining this kind of patient knowledge is less authenticated as a way of knowing by educators. Knowing the patient requires student and patient involvement with each other, a process
facilitated by educators’ support of the connection between student and patient—something which may not be teachable in the traditional sense of applying theory to practice.

According to Benner and Diekelmann (1993), nurse educators are unaware of the importance of fostering this kind of knowledge development because they are too reliant on teaching the importance of nursing care plans, nursing diagnoses, and standard protocols that derive from the positivist, rational model of practice, but overlook and keep hidden the significance of knowing the patient. This is partly because this model assumes that what is important to know about a patient can be explicitly stated and formalized in the problem-solving model of nursing process. But while the model can have a part in promoting holistic care, it can never be complete because it does not make visible the part of nursing that is concerned with understanding the subjective aspects of illness (Latimer, 2008). For Benner, Hooper-Kiriakidis, and Stannard (1993), without individual patient knowledge as the foundation of care, “nursing is reduced to a technology” (p. 279).

Knowing the patient is a phenomenon that depends on using both the paradigmatic and narrative modes of thought. Each has as its end a different outcome. For nursing, these separate outcomes do not corroborate nor contradict each other, but provide different avenues to travel in assembling a composite picture of the patient. It is as important for students to understand the meanings behind narrative thinking, and hence the personhood of the patient, as it is for them to analyze the individual components of the patient’s story for verisimilitude, analysis, and incorporation into a plan of care. By being aware of the narrative’s importance as a structure that people use to organize their own life events into personal stories, the nurse
can understand “the type of coherence that configures a person’s existence into a unity” (Polkinghorne, 1988, p. 183). This kind of awareness becomes even more important when patients who face life-changing diagnoses must rewrite their stories to include new identities and new ways of being in the world.

Carper’s (1978) early scholarship in delineating nursing’s epistemological interests is still often quoted today. She described four patterns of knowing that continue to influence current thinking about the foundations of nursing knowledge. They include:

Empirics – this category parallels Bruner’s paradigmatic model of knowing and includes the generation of theory and of research that is systematic and verifiable. This kind of knowledge is important in describing, explaining, and predicting – the basis of what we now refer to as evidence-based practice.

Esthetics— a way to talk about the art of nursing, refers to recognizing the importance of individual perceptions, empathy, uniqueness of individuals and importance of contextual learning.

Personal knowledge— emphasizes the importance of therapeutic use of self as in presence and therapeutic communication; includes a focus on knowing the patient and striving toward authentic relationships.

Ethics – a focus on what should be done. An important component is recognizing the need to act as advocate in situations in which ethical concerns unfold, and in being sensitive to differences in value systems. Ethics is at the heart of advocacy.
**Storytelling.** Narrative constructions give structure to events and actions in life and allow us to make meaning from experience. Stories are also recognized as a powerful medium for teaching and learning. They can offer examination of personal histories in a way that can lead to reinterpretation and reevaluation of experience. They can also offer ways of being and acting and to explore new ways of life. In this way, stories can contribute to transformative learning (Rossiter, 2002; Pfahl & Wiessner, 2007).

Stories are a central means by which we understand the world, and more importantly, understand ourselves in the world. The storying of our experience—the narrative process—teaches us something of ourselves. Identity is fashioned through the continuity and causality of self, existing across time (Clark & Rossiter, 2008). Bruner (2006) takes storytelling a step further in his analysis of the lives of four people in a family by using these stories to illustrate not only how we “construct ourselves autobiographically” (p. 129)—capture the sense of lived time—but also how the “ways of telling and the ways of conceptualizing that go with them become so habitual that they finally become recipes for structuring experience itself, for laying down routes into memory, for not only guiding the life narrative up to the present but directing it into the future.” (p. 139). Our identities are inevitably bound up in how our life stories are told and retold, interpreted and reinterpreted.

Bruner (2006) explains that stories are central to our meaning making because storytelling is culturally universal, and while cultures are variable, we learn our culture through the stories we tell and listen to about our cultural experiences. Bruner thinks we learn about culture not only by learning about cultural beliefs and practices, and about conflicts that exist
among these aspects of culture, but, more importantly, through the use of story as a medium “for depicting and for resolving the inevitable clash between the conventionally expected and the seemingly unexpected, even the forbidden” (p. 230).

Culture allows us to “know” each other—what Bruner (2006) calls “inter-subjectivity” (p. 231)—a term used often by Watson in describing transpersonal care. Inter-subjectivity refers to a kind of sharing within a culture wherein people feel that they “know” each other’s minds in a way not possible among people from different cultures. It refers to our sense that we know that the other person knows that we know. And, “this gift may actually depend, and certainly relates to our irresistible tendency to understand our social world by couching it in narrative terms. For when we ‘enter’ other minds, we do so through the instrument of narrative” (p. 231).

Although we cannot really read the mind of another, nevertheless inter-subjectivity fosters a certain kind of communication in part because stories are uniformly based on a similar five-dimension (Pentad) structure (Bruner, 2006).

There is an Agent who performs some Action that has some Goal as well as somebody who is its Recipient. It all takes place in some local Setting. Agent, Action, Goal, Recipient. These, interestingly, correspond to….action’s under-lying psychological frame. But to make a story requires some discernible lack of fit between those elements. An Agent’s Action is inappropriate to a particular Setting. Or the Action is ineffective for achieving an intended Goal. Or the Recipient of the Action doesn’t belong in
this *Setting*. Burke calls this *Trouble*, and for him *Trouble* is the

“engine of narrative.” *Trouble* is when the ordinary meets the unexpected, which is what life is like much of the time in any culture. It is the narrative form, then, that provides us with the means of framing the surprises and conflicts that can arise in *any* particular culture. And, of course, the actual *content* of the elements of the Pentad will vary from culture to culture, as will the nature of the *Trouble* created by their discordance.

(Bruner, 2006, p. 231)

Bruner (2006) continues to add insight about what we mean by narrative through his writing describing how we build “what happens” into our stories. Bruner makes the point that storytelling is culturally universal, and that it functions to “instantiate and localize what is conventionally expected in a culture, and also to illustrate the troubles and perils that the conventionally expected may produce” (p. 232). Locating experience within a particular cultural narrative creates coherence for our meaning making -- within a constructivist perspective, a mental ordering from chaos (Clark & Rossiter, 2008).

Not only do we make meaning from experience through our stories; we also forge our identities in the process (Bruner, 2006; Clark & Rossiter, 2008; Wiessner, 2005). Identity, and the closely related concepts of personal change, lifespan development, and even transformative learning are all interrelated constructs that are closely connected to narrative processes (Brooks, 2001; Clark & Rossiter, 2008). While the self can be thought of as an unfolding story, like Bruner, Clark and Rossiter (2008) remind us that we experience this
story in multiple, sometimes contradictory ways and that we are in a constant process of “restorying” ourselves. When a story of self loses coherence—no longer helps us make sense of experience—then we must change our story. It is how we manage the complexity of who we are. The process of “rewriting” the self is essentially a retrospective one: we can only look back to where we were when we are in a better psychological place and see that development has occurred. “The stories of significant transitions throughout life, such as landing a first job, losing a parent, coping with major illness, or retiring from a career, when considered collectively express the meaning one makes of developmental growth throughout one’s life” (Clark & Rossiter, 2008, p. 63).

**Therapeutic value of stories.** Nursing has focused on the therapeutic value of story in caring and healing. Student nurses hear patients’ illness stories through their involvement in student nurse-patient relationships. Hearing patients’ stories is an important component of professional practice learning for students. The telling of stories can benefit the patient by promoting self-hood, and listening to the stories can benefit the student nurse, validating efforts at therapeutic communication.

Although many effects of illness can be observed and measured from the outside, the experience of illness can only be shared in the telling. “In the context of narrative, the individual attempts to find meaning for his or her own purposes as well as those of the listener. How individuals engage in telling their illness stories can be critical to their adjustment to the stress of illness” (Docherty & McColl, 2003).
Patients’ illness stories are narratives patients construct in order to find meaning in the illness experience, especially when the illness is unexpected, life changing, chronic, or life-threatening. These stories are not historical accounts of what happened to the patient, but rather selected anecdotes assembled in a way that the storyteller/patient finds important or meaningful (Frank, 2000). The significance to the patient of telling illness stories can be profound since illness is demoralizing and illness narratives can be therapeutic and emancipatory for patients, helping them cope with their illness, and restoring their sense of self (Carlick & Biley, 2004; Frank, 2000; Hall, 2003; Lee & Poole, 2005; Miczo, 2003; Sakalys, 2003; Skott, 2002).

Critical illness can be a devastating experience that robs the ill person of a sense of self and a sustained identity. Sakalys (2003) describes illness as an “ontological assault” in which one’s power to act is compromised, “productive functioning is lost, and relationships and expectations for the future change” (p. 229). Uncertainty about the future and the body’s response to disease inform the everyday world of the person who is unexpectedly ill. Coping with diagnostic tests, treatment, and side effects become the norm and whatever was familiar about self in the past can no longer be relied on to provide a sense of personhood. The new reality of illness is that the self must now be reinvented (Lee & Poole, 2005).

There is another aspect to illness that is depersonalizing. In today’s healthcare environment a medical model characterizes patient care. It is a model in which the most salient way to relate to the ill person is through a medical diagnosis and a treatment plan—that is, the patient is “medicalized” by virtue of the nature of the system in which care is
given. Frank (2000) describes the phenomenon in discussing how a hospitalized person with a chronic illness becomes a patient but really spends most of his or her time as an ill person. Such an approach tends to define “health, illness, care, and patienthood in terms of disease conditions” (Sakalys, 2003, p. 230). The medical metanarrative is the norm and shapes the meaning of the illness experience. And while the metanarrative is an essential component of the illness experience, it is but one aspect of that experience and it can become hegemonic in that it tends to suppress subjectivity, the uniqueness of the experience, and objectify the person who is the patient. Patients risk internalizing the belief that the medical discourse is the only way to understand the ill self, and compromising their full pursuit of trying to make meaning from the illness (Sakalys, 2003).

Patients can reclaim important aspects of self from the medical metanarrative, and forge out new identities and personhood in the face of illness through storytelling. The illness narrative represents a struggle to maintain a former sense of self and integrate it with a new selfhood, and thereby reverse or mitigate the depersonalization that accompanies being a patient. It is in telling their illness stories that patients are able to again find meaning through a reinterpretation of experience and a reconstruction of self (Sakalys, 2003).

People tell stories to share with others who do not share the same experiences a glimpse of what it means to live by certain values and make certain meanings from the experience. “Others can witness what lives within the storyteller’s community actually look, feel, and sound like” (Frank, 2000, p. 361). Listening to these stories is an acceptance of different beliefs “and of lives in which these beliefs make sense. Whether or how a story
makes sense seems not so much an analytical question as an experiential one: Did the story draw others into its world far enough so that people’s actions in that world seem reasonable in that world?” (p. 361). Through sharing, stories offer multidimensional lenses of the same experience, the same social world.

In working with patients, both the medical narrative of disease and the illness narrative of experience are important. Patients seem far more prepared to tell the medical story than the illness story. But illness narratives are recognized as significant sources of knowledge about how illness can change one’s sense of being in the world (Sakalys, 2003). Nurses are uniquely positioned to hear and affirm the illness story, and telling it can be therapeutic for both the storyteller and the listener. Bell (1997) notes that when illness has affected lives and relationships, “it is important therapeutic work [for nurses] to influence the conversation in a manner that will give voice to the human experience and help patients and family members feel understood” (p. 317).

As Frank (2000) points out, ” . . . the most immediate problem of those who tell stories of illness is to be heard, to find others who will answer their story’s call for a relationship” (p. 355). We, as providers, have to take responsibility to answer that call and enter the storytelling relationship. Attending to these stories is not only the basis for clinical understanding; for Frank, it is, more importantly, the basis for an ethic of care.

Frank (2000) is hopeful that medical culture will change and embrace a new expertise of “listening to patients’ stories about their lives, not only about their diseases” (p. 362), and in so doing make the ill hearable, not eclipsed by the privileged voices of the medical
community. He sees illness narratives as the basis of clinical understanding and as the foundation for practice ethics, and asks how the world would look different if seen from the perspective of the other, the disempowered ones. He charges that creating a space for absent subjects and “filling that space with those subjects’ presence and spoken experience is a form of ethical work” (p. 363). According to Frank, it is less important for us to describe the experiences of the ill than it is “to provide resources for the ill to experience their situations differently” (p. 360). He charges nurses to care, and to show they care through listening.

**Summary**

This chapter reviewed the caring theory of Jean Watson, which serves as a conceptual framework for the study. Literature on the multidimensionality of and the difficulty in defining the concept of caring was presented. The literature included a discussion surrounding elements of concern in the nurse and student nurse patient relationship. Theoretical influences that inform the contextual learning of professional practice were discussed, as well as literature on narratives and storytelling. Included in the latter is a discussion of how nursing students know patients and the relevance patients’ illness stories have as therapeutic aspects of care for the patient.
CHAPTER THREE: METHODOLOGY

Introduction

It is widely accepted that nursing is a caring profession that is holistic in scope. Holistic nursing recognizes that illness is a subjective experience as well as being disease based, and that responses to illness involve mind, body, and spirit. Nursing is also an interpersonal process that requires the formation of nurse-patient interpersonal therapeutic relationships. Nurse caring is an intrinsic part of these relationships (Vouzavali et al., 2011).

Nursing practice within a holistic, caring framework is a standard expected of the graduate baccalaureate nurse as articulated by the American Association of Colleges of Nursing (AACN, 2008). Nursing theory about the meaning of caring as the central aspect of nursing influences models of practice as well as strategies in nursing education (Caruso, Cisar & Pipe, 2008; Clarke et al., 2009; Garno, 2010; Hughes, 1995; Maltby, Drury, & Fischer-Rasmussen, 1995). Nursing students learn the meaning of caring in practice through clinical experiences in student nurse–patient relationships. However, little nursing education research about caring looks at the phenomenon from the perspective of the nursing student (Suikkala et al., 2008). Although it is thought to be at the heart of nursing, the characteristics of caring in an interpersonal relationship between the nursing student and the patient, its meaning for the student, the factors that affect it, and its impact on the student are not well understood.

This study explored how nursing students experienced caring relationships as they interacted with patients in their clinical courses and developed as practitioners. The research
question guiding the study was: *How do nursing students experience caring relationships with patients?*

This chapter presents the design and methodology for the study. It explains why a qualitative approach using a narrative case study methodology was chosen to address the research question, and how this methodology influenced data collection and analysis strategies. A description of the study setting and the participant selection process are included, as well as a discussion of issues of trustworthiness, verification, researcher positionality, and the limitations of the study.

**Rationale for Qualitative Research**

Understanding the meaning of experience is a goal of qualitative research. Creswell (2013) explains that qualitative research takes place in a natural setting where researchers typically collect data themselves, and analyze them inductively to learn the meaning that participants hold about a problem or issue. In contrast to quantitative research, in which conditions are controlled and manipulated to yield an objective analysis of phenomenon for purposes of prediction, qualitative research is conducted in the real world to explore multiple dimensions of experience for the purpose of interpreting and understanding human action. Proponents of qualitative research appreciate its ability to explore facets of human experience that allow the researcher to gain an in-depth perspective of participants’ thoughts, feelings, beliefs, values, and assumptive worlds (Marshall & Rossman, 2006; Sandelowski & Barroso, 2007). Qualitative research is inquiry-guided, offering a range of approaches to the
fundamental question, “What’s going on?” Its focus is on understanding the particulars of events or actions in context (Katz & Mishler, 2003).

The interpretive aspect of qualitative research makes it well suited for an exploration of how students negotiate meaning from events in their clinical experiences (Marshall & Rossman, 2006; Merriam, 2002; Munhall, 2007). A qualitative methodology is also consistent with a constructivist view of knowledge in which knowledge is seen as not objective but as being created inter-subjectively, in a particular social context. The province of qualitative research is to allow multiple perspectives on a topic, and to make tacit knowledge and subjective interpretations possible (Creswell, 2013; Marshall & Rossman, 2006).

Rationale for a Narrative Case Study Approach

Case study is one of many approaches to qualitative research. It is a preferred method, compared to other methods, when, as in this study, the research question posed asks “how” in relation to the phenomenon to be studied (Yin, 2014). A principal objective of case study research is to achieve a deep understanding of processes and concepts such as participants’ self perceptions of their own thinking processes, intentions, and contextual influences regarding what is happening and why they did what they did (Woodside, 2010). Because this study was exploratory in nature, and I was looking for an in depth understanding of a contemporary phenomenon in a real-world setting involving important contextual factors pertinent to the case, case study was an appropriate method of inquiry (Yin, 2014).
A requirement for case study research is that the “case” be a “specific, complex, functioning thing,” a bounded system with integrated working parts (Stake, 1995, p. 2). Bounding cases sets limits on what is to be studied and what will not be included in the case (Sangster-Gormley (2013). My study was bounded by its focus on caring relationships among nursing students enrolled in an undergraduate program at a school of nursing. The study is what Stake (1995) refers to as an intrinsic case study, as opposed to an instrumental one. When a case is intrinsic, it reflects the researcher’s interest in understanding a particular social phenomenon; an instrumental case seeks the same understanding but its purpose is to gain insight into a larger problem or issue through the case. Stake (1995) points out the distinction is important in choosing a case, as the choice of a case as instrumental considers how best to represent the larger, more general issue of interest. This intrinsic case represents my interest in learning the particulars about caring relationships among a certain group of students.

**Use of Narratives**

Clandinin and Connelly (2000) note that one way to conduct case-centered research, based on the theoretical view that experience is made meaningful through story, is to examine stories about experience. Within the structure of a case study methodology, this study looked at how stories conveyed the meaning of a particular experience or event for the one who had it and told about it in story (Kramp, 2004). The data in the study was comprised of stories students shared in interviews and critical incident papers. Stories were analyzed to explore and describe what students found meaningful to talk about regarding their caring
relationships with patients. By examining stories, I was able to look more deeply into the student experience of caring—at descriptions that allowed insight into the interior aspect of the experience, into attitudes about caring, and into related affective learning, for example. Through telling and reflecting on stories, students explored their own perceptions of characteristics of their learning that did not fall within an analytic paradigm, and tapped into any tacit understandings they may have had about themselves in the context of developing caring as a professional value (Riessman, 2008). Since it is an assumption that through narratives people construct and reconstruct identity, in sharing stories about clinical experiences, students may also have become more aware of themselves as beginning caregivers. Storytelling may have offered them a way to articulate aspects of their developing professional selves, which they may not have been aware of until sharing their stories made the meaning of their experiences more explicit to them (Chase, 2005; Clandinin & Connelly, 2000; Marshall & Rossman, 2006; Moen, 2006).

There are many accepted but different definitions for the term “narrative.” In this study, the concept of narrative was operationalized to cover the following applications and elements: something that is narrated, such as a story or an account, or the representation in art of an event or story (Merriam-Webster, n.d.). Narratives have contingent sequences, and a consequential linking of events or ideas. A condition of narrative is the imposing of a meaningful pattern on what would otherwise be considered random and disconnected. Narratives in this study included spoken and written materials (Riessman, 2008).
Although for some “narrative” has the same meaning as “story”, and story and narrative do share common elements, in this study narrative is considered the broader term that includes story (Riessman, 2008). Narratives can describe, for example, conversations, professional encounters, historical and scientific accounts. Narratives and stories can also differ in that stories will have a point expressed by the attribution of meaning to the sequencing of events (Mishler, 1995).

**Research Design**

**Study Setting Selection**

The setting for this study was a school of nursing at a major public research university (hereafter referred to as Omega University) in the southeast which enrolls over 29,000 students and where the undergraduate nursing program was likely similar to those at other schools in comparable four-year institutions. Students begin the nursing program in their junior year after completing lower division university and nursing program prerequisites.

The curricula leading to the bachelor of science in nursing (BSN) degree offers two options for study: 1) two years of upper-division courses in the School of Nursing which follow two years of lower-division courses in the General College (BSN Option); 2) an accelerated second degree option for students with a previous bachelor’s degree (ABSN Option). Students in the two-year and accelerated options follow the same curriculum, but do so at different paces.
Participant Selection

The participant pool for this study drew on the pre-licensure students in the BSN and ABSN options. Inclusion was based on the following criteria: 1) enrollment in either the BSN or ABSN option; 2) completion of the introduction to nursing fundamentals course; 3) completion of the first adult health clinical course in the curriculum; 4) no prior interaction with the researcher; 5) willingness to submit a critical incident paper written as a requirement for a clinical course.

Students enrolled in BSN and ABSN options are taught patient-centered communication skills in their introductory nursing fundamentals course. They develop these skills in subsequent courses throughout the program, most often in courses with a clinical component where they have opportunities to communicate with patients. Because this study looked at how students experienced caring relationships with patients, having had opportunities to communicate with patients and form student nurse-patient caring relationships was fundamental to participate. Further, because I am a faculty member in the School and did not want to have any undue influence on student responses in the study, only students who had not had any interaction, and would not have any future interaction with me were included in the participant pool.

All students in this pool were invited to participate in the study. However, they were at different points in their completion of the program. An assumption of the researcher was that with clinical experience, students improve their communication and interpersonal skills, become more confident in implementing them, and are then more likely to be able to form
and maintain caring relationships. Therefore, the selection of study participants from the pool of students who expressed an interest in the study was based on the number of clinical courses completed. Interested participants who had completed three clinical courses were selected first. Additional participants were needed and were recruited from among those interested students who had completed at least one clinical course.

**Recruitment Activities**

Approval of the study by an Institutional Review Board (IRB) affords participants protection from harm and ensures that the reasons for conducting the study, and how findings from the study will be disseminated, are transparent and clear (Marshall & Rossman, 2006). The IRB approval from two universities was obtained for this study. Approval for the study was obtained through submission of an application to the North Carolina State University IRB. Approval was also obtained from the Omega University IRB in keeping with their procedures to be followed for researchers whose study is affiliated with a different university.

After obtaining IRB approval from the Boards of both universities, I followed the Omega University School of Nursing Policy and Procedures for Accessing School of Nursing Students for Participation in a Research Project. Per this policy, I first submitted a plan for recruiting students to the Associate Dean for Academic Affairs. The policy is included as Appendix E.

After the Associate Dean approved the study, I took the following steps to recruit students from the participant pool:
with the permission of the coordinators of courses in which the pool of possible participants were enrolled, explained to students during a class meeting the purpose and design of the study, its expected timeframe, and the anticipated time commitment required of them

- sent a follow-up email to students one week after the class meeting again explaining the study, requesting student participation in the study, and explaining how to enroll in the study. The email
  -- included a participation form to be returned to me. The form asked the student to indicate which courses he or she had completed and gave me the student’s desired contact information.
  -- included a consent form giving me permission to use the student’s critical incident paper. The students returned the consent form with the participation form.
  -- asked the student to attach a copy of a critical incident paper he or she had written as a requirement in a completed clinical course.

- posted flyers recruiting participants on bulletin boards in the School.

Students were told that they might be asked to participate in no more than a 90 minute interview in which they would be asked to talk about patient care experiences, including those that led them to write their critical incident paper. The email was sent to the appropriate listservs by the Office of Academic Affairs, who also facilitated recruitment by posting the informational flyers from the investigator in the School. All of the communication materials
used in recruiting students are included as appendices with the North Carolina State University Institutional Review Board application.

The goal of recruitment was to obtain approximately 15 participants. Fifteen students expressed an interest in participating in the study and made up the sample quota. All students were chosen to participate as their critical incident papers reflected stories that included some aspect of being in a student nurse-patient relationship. After participants were selected, interview schedules were arranged in keeping with student availability and scheduling preferences. Students were asked to sign a second consent form to enroll in the study prior to beginning the interview, after I answered any questions concerning their participation.

It is important that researchers conduct studies in an ethical manner. Because the researcher is a faculty member in the School where the study was conducted, it was possible students did not want to be candid in their interview responses. They may have wanted to project positive self-images and give what they thought were acceptable responses. They may also have thought their true understandings about some clinical situations would not be welcomed or accepted (Polkinghorne, 2007). Students could have perceived that if they said anything negative about their learning experience, their comments could somehow affect their standing in a course.

Participants were informed that their anonymity would be protected, that all conversations would be kept confidential, and that they could choose to not answer any interview questions. In addition, I kept an open listening stance during the interviews, communicating acceptance of students’ portrayals of their experiences, and encouraging
them to express the true meanings they found in their stories (Polkinghorne, 2007). I also ensured that students understood my interest in hearing their stories and using the information they provided was solely to understand student learning. Students were informed that they could withdraw from the study at any point. Member checks were explained to them. They were told that they would have the opportunity to review their interview transcripts, share their reactions to the transcripts with me, and modify the transcripts if they wished to ensure the transcripts reflected what they intended to communicate.

Data Collection

A relevant feature of narrative case study as a form of inquiry is the use of multiple sources of evidence converging in a triangulation fashion (Yin, 2014). The sources of data in this study were documents (critical incident papers); interviews; a researcher log, which consisted of field notes; memos and ongoing commentaries; and contact summary sheets for each participant.

Critical Incident Papers

Each student submitted a critical incident paper to me by email prior to participation in the study. These critical incident papers described clinical experiences of significance for students. The documents comprised the first phase in the data collection process.

Originally a research method first used by Flanagan in 1954, the critical incident technique continues to be a popular tool in qualitative research methodologies as well as in various disciplines including nursing education. Butterfield, Borgen, Amundson and Maglio (2005) point out that although the critical incident technique has changed and evolved over
time, a distinctive feature of the technique continues to be its focus on critical events, factors, or incidents that help promote or detract from “the effective performance of some activity or the experience of a specific situation or event” (p. 484). A critical incident is one that has impacted the performance of the student in his or her professional role and may reveal a change in understanding or worldview (Webster & Mertova, 2007).

In the School, a critical incident paper was a required assignment in clinical courses. In part, the purpose of the paper was to provide an opportunity for students to reflect on a clinical experience, and to show progress in developing clinical reasoning and clinical judgment as they advanced in the program. A template, common across clinical courses, directed the content and format of the paper. Students were asked to discuss a nursing problem in the paper, explain its significance to them, and tell how they responded to the problem and how they were affected by it. The template for the critical incident paper is included as Appendix I.

Student names were removed and pseudonyms assigned to the critical incident papers used as data in this study. The papers were reviewed for the presence of stories about events surrounding student–patient relationships. All student papers contained stories that described an aspect of a student nurse-patient relationship, and interviews were set up for all students. In the interviews, students were asked to talk about the incident they described in their papers and to also relate information about other more recent clinical learning experiences. The papers were thematically coded. Themes identified in the stories gave me points of reference to help guide the direction of the interviews, and helped students reflect on the incidents they
described in their papers. Student responses during the interviews clarified, corroborated, and/or elaborated on themes identified in their papers. Critical incident papers thus served as narrative data and as aids to students in revisiting a particular past clinical event. Respondents were thought to be more likely to talk about a particular event from the past if it stood out for them as significant or exceptional (McCance et al., 2001).

**Interviews**

Interviews were a second source of data for this study. Interviews were suitable tools for data collection because face-to-face interaction between researcher and participant was vital in creating and understanding the unfolding meaning making that happened when study participants told their stories. The purpose of the interview was to capture the participants’ own sense of reality. It was an important source of evidence because it provided insightful personal views, perceptions, attitudes, and meanings of participants (Yin, 2014). As Yin (2014) points out, in interviews, it is the interviewee’s perceptions and own sense of meaning that are the material to be understood. Because stories emerged through the interactions of researcher and interviewee, interviews were also a good generative method for narrative data.

The interviews were semi-structured—ones in which a number of questions were prepared in advance but subsequent questions were improvised in a careful way based on what participants said in response to the initial questions. Semi-structured interviews using primarily open-ended questions helped the development of rapport with the participants, allowed participants to tell their stories in an unhampered way, and the interviewer to interact with them and draw out elements of their stories by querying interesting comments that
seemed to influence meaning (Wengraf, 2001). Semi-structured interviews are not constraining and allow participants to focus on their individual lived experiences and capture the meaning of the experience in their own words (Marshall & Rossman, 2006). Because they are not constraining, semi-structured interviews can also help balance the power relationship implicit in a research interview mitigating the researcher’s position of authority (Mishler, 1986). Their use was consistent with the researcher’s belief that participants’ intentions and interpretations were as important as those of the researcher (Gubrium & Holstein, 2009). In order to further encourage communicative equality, and facilitate active participation of interviewer and student, the interviews were conversational in tone (Riessman, 2008). Each student was assigned a pseudonym to ensure anonymity prior to the beginning of the interview. All interview data was kept confidential.

The interviews were approximately one to one and one-half hours in length. Interviews were held in a conference room in the School of Nursing. Students had been asked to choose an interview time from available options. Because meeting in the School made it possible for students to be recognized by others as participants in the study, interview times were arranged according to student choice and convenience. Interviews were digitally taped using two separate recording devices.

In the interviews, students were asked to elaborate on the events they described in their critical incident papers as well as share other patient experiences. In addition to their critical incident experience, they were specifically asked to recall experiences that were significant, critical or problematic to them—ones, for example, that gave the student
particular insight into understanding an aspect of a particular patient’s experience, were meaningful because they struck an emotional or empathetic chord in the student, or were problematic to the student in some way. Interview questions were open-ended and are included in the Interview Guide (Appendix A).

Member checks through review of the interview transcripts were done to ensure the accuracy of the data. After the interviews were transcribed, the transcriptions were sent to students by email for their review, clarification and comments. Students were given an opportunity to change information in the transcripts if they wished so that students and myself would have a clear and shared understanding of the accuracy of the data (Miles & Huberman, 1994). No students requested that changes be made in their transcripts.

**Researcher Log**

A researcher log was kept throughout the research process. The log consisted of field notes and memos used to record observations and immediate and emerging thoughts about the interviews and about the concepts being discovered in them. These thoughts included, for example, comments about non-verbal behavior noticed during the interview process. The log included the researcher’s thoughts about consolidating themes, inferences made from the data and alternate interpretations considered. Details about decision points made along the way in deciding on inferences and choosing themes was included in the log. In this way, the researcher log served as an audit trail (Miles & Huberman, 1994; Riessman, 2008).
Contact Summary Sheets

A contact summary sheet was created for each participant prior to his or her interview and completed after field notes were written up and reviewed. Contact summary sheets supplemented field notes by providing a way to begin data reduction, capture thoughtful impressions and reflections, and summarize and organize data so that it could be easily retrieved. The contact summary sheet information reoriented the researcher to the contact when returning to the transcript. Information included on the contact summary sheet was the date of the interview, and demographic data – age, gender, course currently being taken, and whether the student was enrolled in the BSN or ABSN option (Miles & Huberman, 1994). A sample contact summary sheet is included in Appendix H.

Data Analysis

“Data analysis consists of examining, categorizing, tabulating, testing, or otherwise recombining evidence, to produce empirically based findings” (Yin, 2014, p. 132). Analysis allows researchers to study contextual detail in order to provide rich, deep descriptions of findings (Sangster-Gormley, 2013). The analysis of data in the study began during the data collection process, as I was reading critical incident papers prior to interviews to arrive at a preliminary set of possible themes. Themes, sometimes called categories, are broad units of information that have been aggregated from codes. Data analysis continued through numerous cycles of interrelated and sometimes simultaneous steps of reducing, representing and interpreting the data (Creswell, 2013).
Because my data consisted primarily of narratives, I used a narrative analysis approach to analyze data. Kramp (2004) explained that we come to endow experience with meaning through story. Since my study’s purpose was to describe how students experienced caring relationships, and stories were considered portals into what they considered important about their experiences, the initial step in this approach was to identify the stories, first in the critical incident papers and later in the interview transcripts. A segment of text in an interview transcript or critical incident paper was considered a story if it was bounded by an event or happening and had the following conditions: the information offered was temporally situated; the text had contingent sequences and a consequential linking of events or ideas; there was a context for understanding meaning in the text; the text had a meaningful overall pattern; in the telling, the narrator of the text attributed meaning to the sequencing of events (McCance et al., 2001; Mishler, 1995; Riessman, 2008).

The approach used to interpret student stories was thematic analysis. Thematic analysis focuses on analyzing the meaning of a story based on its content -- “what” is spoken or written -- as opposed to other possible types of narrative analysis strategies that look, for example, at structure or form, examining “how” stories are told (Reissman, 2008). Thematic analysis was chosen as an approach because theory about narrative knowing assumes the act of participants’ choosing what to include in their stories involves making sense of experience, that is, their deciding what to include as seminal and how to locate events and actions in their stories. These content pieces were a key focus, illuminating how the students
experienced caring relationships (Goldsmith, Wittenberg-Lyles, Rodriguez, & Sanchez-Reilly, 2010).

Qualitative methods can generate a voluminous amount of data (Creswell, 2013; Miles & Huberman, 1994). The data in the study consisted of approximately 450 pages of text—300 pages of interview transcripts and 150 pages of critical incident papers. To avoid data overload, I followed Miles and Huberman’s (1994) recommendation to be mindful of the purpose of my study and its conceptual framework. Keeping my research question and conceptual framework in mind as a lens, I analyzed critical incident papers, and later interview transcripts, by reading through them at least three times while making notes in the margins. In my initial analysis I was looking for repetition of ideas and concepts that suggested initial codes and might eventually make up themes (Bernard & Ryan, 2010). This process resulted in the first cycle of open coding.

Open coding refers to the first step in how a researcher assigns meaning to units of descriptive and inferential data (Miles & Huberman, 1994). Coding interview transcripts and critical incident papers involved making a choice about the significance of “chunks” of information in a given context. Chunks of data included descriptive words, phrases, sentences, or repeating ideas that describe behaviors, beliefs, ways of thinking, or particular actions (Miles & Huberman, 1994). After coding the critical incident papers, I continued the analysis in a similar manner using interview data. These steps in analysis involved numerous cycles of successive levels of open coding, collapsing and consolidating codes, searching for promising insights, concepts, and patterns (Yin, 2014).
The goal of this main categorizing strategy was data reduction, that is, “the process of selecting, focusing, simplifying, abstracting, and transforming the data” (Miles & Huberman, 1994, p. 10). Coding is a means of condensation and analysis of data that moves the researcher forward by bridging the gap between the texts and the research concern. Different levels of analysis are needed that range from making the text manageable by selecting relevant text through open coding, to understanding what was said by participants through identifying themes and forming general concepts by combining and collapsing themes. The central idea of coding is to move systematically from the text to the research concerns through a sequential process of inference, moving from a lower level of understanding to a more abstract level of comprehension (Auerbach, 2003).

After completing an empirically guided open coding process, I began a second round of coding using concepts from Watson’s theory of human care (Watson, 2007) so that theory oriented codes might also be considered in examining the data (Riessman, 2008). Key components in Watson’s theory of human caring – caring processes, the caring occasion, and transpersonal caring—were referenced as guides in theoretical coding. These concepts helped in inferential analysis by providing a schema for me to consider while selectively sorting through the texts. Some elements in student narratives initially seemed to align with Watson’s concepts of transpersonal care, caring occasions, and caring processes, but codes for the concepts seemed to be too empirically ill fitting and therefore not helpful in interpreting the data. Theoretical coding did offer a clear delineation of the lived experiences of the students and did not prove useful.
To enhance reliability of empiric codes, another nurse educator provided an independent review of the coded materials. She did not recognize any substantial differences in understandings of how codes were assigned, or in the language used in the codes, between her inferences and mine.

After open coding was completed and descriptive codes were generated, memoing was done to elaborate on the codes, and connect them together by providing a write-up about the codes and their relationships until an interpretation of substantive themes became clear (Auerbach, 2003; Maxwell, 2005). A codebook with definitions for each code was kept and revised as a key part of the inductive coding process. The coding process was more cyclical than linear, and during coding and analysis, I added and consolidated codes and themes, and modified them as understandings became clearer and more central to the overriding research concern (Auerbach, 2003). Alternative understandings of interpretations and negative cases that required different interpretations were considered (Marshall & Rossman, 2006).

A visual display of the data was created to facilitate higher levels of abstraction in interpreting the themes. Miles and Huberman (1994) point out that displaying data in a visual format is a way to present the data systematically so the researcher can draw valid conclusions. I had inductively generated a set of common themes from the individual sets of themes in each story. For the data display, I wrote each of 30 themes on 8 ½” x 11” sheets of paper. I re-read stories and each time I was satisfied I had a sub-theme to support each theme, I placed it on a post-it note with the participant’s name and the page number in the text under that theme. A significant cluster of sub-themes indicated a theme was a major conceptual
theme; few post-it notes on a particular theme indicated few students had spoken about experiences in that particular category and these themes were deemed of less central importance in illustrating meaning in the data. In the process of relating individual themes in student stories to the larger themes, it became clear that certain themes and sub-themes were present in stories of experiences at different points in the curriculum.

The visual display was a way to illustrate themes in relation to each other. I could consolidate, rename, and move themes to different places on the wall as I gained higher inferential levels of understanding. “Caring for Vulnerable Patients,” for example, was subsumed under the broader theme, “Acting as a Patient Advocate.” Eventually a theme common across stories emerged suggesting that how students experienced caring relationships was a phenomenon associated with the development of their learning. It appeared to be central across a wide range of experiences in the narratives, yet was personalized in each student’s unique stories of caring experiences.

**Researcher Positionality**

“Qualitative researchers have long recognized that . . . the researcher *is* the instrument of the research” (Maxwell, 2005, p. 37). In this study, as in many nursing studies, a strong autobiographical element drives the research (Marshall & Rossman, 2006). I am deeply immersed in the teaching of nursing and am on the faculty at the School where I conducted the study. I have been a nurse for over twenty-five years and during a large part of that time, have been a nurse educator working with undergraduate students. Strongly influenced by a nurse educator mentor early in my career, I believed student learning was optimal when the
bar was held high enough to challenge students to do their best work, and expectations were clear about how to attain excellence. This belief influenced my philosophy of teaching. I thought of nursing as a discipline that required a broad knowledge base, provided challenging problem-solving situations, and was always changing, requiring a nurse to acquire new knowledge and skills to remain competent. I believed to be good nurses students needed strong academics, and the personal qualities that enabled them to meet the intellectual, social, and emotional demands of the profession.

Having had opportunities to teach in courses that book-ended curricula, and to work with a wide array of students at different levels in their programs, broadened my view of what made a “good” nursing student. I learned that many students were not academically gifted and many might not become exemplary professionals. Yet, they were good students and would become good nurses. One important thing I learned from my teaching was that students who became good nurses also cared about their patients.

In light of this perspective, I recognized the importance of caring relationships to students and to patients. I had communicated to students the importance of learning pathophysiology, pharmacology, medical problems and their clinical presentation, and the nursing care and procedures associated with a care plan. Students communicated to me their perceptions of the meaningfulness of the connections they made with their patients.

I believe caring is central to nursing and involves knowing the patient in ways that go beyond understanding medical knowledge about the patient’s diagnosis. I believe how a
patient is experiencing and responding subjectively to an illness is important for a student to understand. Nursing literature describes how providing care solely within a biomedical paradigm depersonalizes the patient. Literature supports the importance to the patient of being able to tell his or her story and to have the story heard. It seems important, then, that students understand the power and therapeutic benefit to patients of being in a caring relationship.

Marshall and Rossman (2006) point out that a researcher must meet criteria for soundness by making explicit any researcher bias or assumptions that influence the study. I disclose my positionality in regard to caring relationships in this study so that my personal lens and the underlying assumptions that influenced and shaped the study are evident. Constantly remaining self-aware and self-reflective regarding my assumptions and personal vision of nursing hopefully allowed me to recognize how this bias could influence data collection and my interpretations of the data (Marshall & Rossman, 2006). As Maxwell (2005) pointed out, the most important point when considering researcher bias is for the researcher to understand how she influences what the interviewee says, and how this affects the validity of the inferences the researcher draws. When assumptions underlying a study are made explicit, and connections about how inferences made in the study are clear, the strength of the explanations arrived at can more accurately be assessed (Miles & Huberman, 1994).

**Issues of Trustworthiness**

Qualitative research studies are grounded in an epistemology of interpretive paradigms, and are expected to demonstrate their soundness when evaluated against these.
paradigms (Riessman, 2008). Riessman (2008) names feminist, phenomenological, and constructivist perspectives as examples of these paradigms. In qualitative research, writers sometimes find qualitative equivalents that “parallel traditional quantitative approaches to validity” (Creswell, 1998, p. 197). The concept of trustworthiness has a purpose similar to that of reliability and validity in quantitative research, but is used in qualitative research because it has a somewhat different meaning than these quantitatively framed terms (Creswell, 1998, Lincoln, 1995; Marshall & Rossman, 2006; Shenton, 2004).

According to Lincoln (1995) and Creswell (2013) there are multiple perspectives on and procedures for establishing trustworthiness in qualitative research. However, four accepted criteria, corresponding to concepts used in quantitative research, can establish trustworthiness for the qualitative researcher. They are credibility, which corresponds to internal validity and seeks to answer the questions of how credible the findings are in a particular study. A second concept is transferability, which corresponds to the concept of external validity, and represents how applicable the findings are to another group of people or a setting. Dependability—whether we can be reasonably sure the findings would be the same if we conducted the study again with the same participants in the same setting—parallels reliability. And confirmability relates to objectivity—how we can be sure the findings are not a fabrication of the researcher but reflect the views of the participants.

**Credibility**

Credibility in this study was established by demonstrating that the case study was conducted in a way that made clear how the focus of the study was identified and described.
The study presented data that reflected an understanding of the phenomenon that was examined. An in-depth description that made the complexities of the processes and interactions that occurred in the study transparent are embedded with data derived from the study (Marshall & Rossman, 2006). Credibility in this study rests on the extent to which data reflect context-rich, thick descriptions that conveyed the student experience being investigated and the context of this experience (Marshall & Rossman, 2006; Miles & Huberman, 1999; Shenton, 2004).

**Transferability**

To be trustworthy, a study will have transferability. Transferability means that findings can be useful to others using similar settings and a similar research question (Marshall & Rossman, 2006). Detailed methodological information and thick, rich descriptions of contexts provided transparency so other investigators can follow what was done in this study and determine whether the findings can be transferred (Creswell, 2013). The methodological information included made explicit how methodological decisions were made; described how interpretations were produced, including alternative interpretations considered; and ensured that primary data could be made available to other investigators (Marshall & Rossman, 2006).

**Dependability**

Some researchers equate dependability with reliability, that is, try to determine if a study can be replicated using the same participants, setting, and method. This investigator established dependability by making explicit the processes that made up the study—selection
of participants, data collection and interpretation of transcripts, field notes kept, contact summaries created, and steps in coding and data analysis, for example—so that another researcher would be clear about what was done if trying to demonstrate similar steps leading to similar conclusions (Shenton, 2004).

**Confirmability**

Lastly, trustworthiness includes confirmability—the condition of being able to verify that the findings are “the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher” (Shenton, 2004, p. 72). A question raised in evaluating confirmability is whether unacknowledged researcher bias exists (Miles & Huberman, 1996). Confirmability in this study was established by making explicit an audit trail of evidence from which the interpretive account was made, as well as the researcher’s positionality and the evidence that showed how the interpretation of meaning was constructed.

In summary, criteria to evaluate the soundness of qualitative research incorporates the concepts of credibility, dependability, transferability and confirmability. Meeting the conditions set forth in these concepts relies not on the veracity of the participants or on the absence of researcher bias, but on the provision of enough detailed information to make explicit the kind of information needed to substantiate these concepts. To this end, the audit trail provided in this study—recorded conversations that represent what was said, and the researcher’s log of decisions and inferences made during the course of the project, such as what interpretations of the data were considered, which not considered, and how final
interpretations were made—made explicit how the research was done and enables future investigators to evaluate the work as trustworthy, that is, whether or not it is “worthwhile to pursue as a line of inquiry and/or a springboard for future work” (Riessman, 2008).

**Standards of Verification**

While qualitative research is guided by general standards of trustworthiness, within each tradition of inquiry, specific standards of verification ensure the quality of the study (Creswell, 2013). Stake (1995) notes the importance of case study protocols to minimize misrepresentation and misunderstanding in our work, and make sure our interpretations are not based on intuition and only the intention to “get it right” (p. 107). The primary means of verification in case study research is triangulation. Through triangulation we establish meaning by viewing our interpretations from different perspectives. If these perspectives converge on the same interpretation, we have multiple measures of the same phenomenon and our interpretation is triangulated.

Denzin (1984) identified protocols for triangulation. These protocols include data source triangulation--looking to see if the case remains the same at other times and in other places or as persons react differently; investigator triangulation—having other researchers look at the same phenomenon; theory triangulation—obtaining the perspectives of other reviewers with a different theory predisposition; and methodological triangulation -- using multiple methods focused on the same construct from independent points of observation. This study used the latter form of triangulation by using document review and interviews as sources of evidence. However, Stake (1995) points out that qualitative research assumes a
constructivist epistemology, and “the stronger one’s belief in constructed reality, the more difficult it is to believe that any complex observation or interpretation can be triangulated” (p. 114). I share a constructivist epistemology. For this study, following a protocol for triangulation reflected a search for additional, related interpretations offering multiple views on stories of caring relationship experiences (Flick, 1992).

Participants also have a role in triangulation through member checks. Member checks involve asking the participants to review the data for accuracy and confirm that it represents what they intended to communicate, or indicate changes they feel should be made in the text. In this study, I sent the interview transcripts to the students and asked for their revisions or confirmations that the data was acceptable for use in the study. No students requested that any changes be made to their transcripts.

**Limitations**

Findings in this study are limited to nursing students who have partially completed their program of study in a baccalaureate program. The study is bounded within a large, public research university’s School of Nursing, and findings are limited by the small sample size and the selectivity of these particular students in the School. Curricula and student body characteristics in nursing education programs vary and these differences may affect the range and characteristics of student responses and thus the interpretation of findings (Marshall & Rossman, 2006).

An additional limitation to this study may be that students at the novice level have had little experience with patients, and may lack the self-awareness and reflection skills that
would enable them to convey rich descriptions in their stories. Also, this study focused on experiences when students had only been with a patient for a few days. Relationships change and develop over time. The brevity of the relationships students developed may have affected their potential to develop a deepening association with a patient, and even limit what the student recalls from the interactions. Participating students were not observed in the clinical setting in the actual process of interacting with patients. Observations of their interactions could have supplemented and enriched the data that was collected in the study.

Other limitations in this study are related to the qualitative methodology used and to elements in the research design. All qualitative research is influence by the researcher’s subjectivity. Each researcher, like a photographer, views the research design and interpretation of data through a particular lens, based on certain assumptions. In an interview, for example, the researcher brings a certain perspective that influences how she listens and questions the participant, and may shape the stories participants choose to tell. The same influence can occur during the transcription and interpretative processes. In fixing the information gathered into written form, and analyzing the meaning of the data, prior researcher assumptions can play a role. It is important that the researcher recognize assumptions and how they influence her role, and that other interpretations of the data must be considered (Miles & Huberman, 1994).

A related limitation is that of participant reactivity (Maxwell, 2005). Because the participants were made aware that I am on the faculty at the School, their responses may have been influenced or affected in some way. They may have tried to impress me by
offering responses they thought I was looking for, or which they perceived would be helpful to me. Alternatively, some participants may have reacted by being less forthcoming and open in telling their stories.

To address these limitations and minimize the impact of possible alternative interpretations of the data, coding schemes were carefully reviewed by the researcher and by a peer nurse educator. To address the problem of participant reactivity, the researcher made a conscious effort to use open and honest dialogue to create an environment that was inclusive to listening to all forms of stories. The researcher also used field notes that include observations of participants’ non-verbal communication and expressive details as well as the interviewers’ verbal cues, to increase awareness of how her role may have influenced the interview process.

**Summary**

Chapter three presented the qualitative methodology that was used to explore the experiences of nursing students in caring relationships. The design of the study was discussed, including the use of a narrative case study methodology, site and participant selection, recruitment activities, and data collection and data analysis methods. The chapter includes a discussion of issues of trustworthiness, triangulation, researcher positionality, and the limitations of the study.
CHAPTER FOUR: FINDINGS

Introduction

This qualitative, descriptive narrative case study explored how undergraduate nursing students experienced caring in student nurse-patient relationships. Caring has been described as the cornerstone of nursing, and as an integral part of holistic care. Caring has been studied extensively in the nursing literature from both a theoretical perspective and from the perspectives of the nurses who provide care and the patients who receive care (Lukose, 2011; Morse et al., 1990; Swanson, 1991, 1993; Watson, 1997). In this study exploring caring from the student nurse perspective, the multi-dimensional nature of how students experienced caring relationships with patients is described. Study findings illuminate how students came to personal understandings of the meaning of caring relationships, and relatedly, the meaning of caring for them in terms of who they wanted to be as nurses. The guiding research question for the study was: How do nursing students experience caring relationships with patients?

Undergraduate nursing students enrolled in a baccalaureate program at a major university in the southeast (herein referred to as Omega University) provided rich descriptions of patient care experiences during their clinical courses. All students had submitted critical incident papers, written as a requirement in their first clinical course. The critical incidents were used to guide later interviews in which students were asked to recall and elaborate on the experiences they wrote about in their papers, and to share additional, related experiences. In their responses students shared stories about what it was like to be in a
relationship with a patient, and how that relationship looked to them when examined through a caring lens. Students were at different points in the curriculum at the time of the interviews, and their reflections spanned experiences in all their clinical courses. This chapter will present findings that describe core thematic content surrounding students’ perceptions of their experiences in student nurse-patient relationships.

**Profile of Research Sample**

Fifteen undergraduate pre-licensure nursing students enrolled in the School of Nursing at Omega University participated in this study. They were junior and senior level students who had completed between three and five clinical courses respectively at the time the data was collected. The sample included 12 female and three male students whose ages ranged from 20 to 44. The average age of the students was 26 and the median age was 23. In addition to the traditional two-year program, the School of Nursing offered an accelerated option for students who had completed a bachelor’s degree in a field other than nursing. In this sample, 10 participants were students in the traditional Bachelor of Science in Nursing (BSN) option, and five students were in the accelerated Bachelor of Science in Nursing (ABSN) option. In the degree populations, ages and gender of students were similar within the options. In this study, the BSN students ranged in age from 20 – 44; in the ABSN, 23 – 38. There were two male students in the BSN group and one male student in the ABSN group. Note a summary of participant information in Table 1.
### Table 1
**Demographics of Participants**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Age</th>
<th>Degree Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Beth</td>
<td>F</td>
<td>23</td>
<td>ABSN</td>
</tr>
<tr>
<td>2. Bob</td>
<td>M</td>
<td>29</td>
<td>BSN</td>
</tr>
<tr>
<td>3. Carrie</td>
<td>F</td>
<td>20</td>
<td>BSN</td>
</tr>
<tr>
<td>4. Holly</td>
<td>F</td>
<td>23</td>
<td>ABSN</td>
</tr>
<tr>
<td>5. Isabel</td>
<td>F</td>
<td>22</td>
<td>BSN</td>
</tr>
<tr>
<td>6. Isabella</td>
<td>F</td>
<td>22</td>
<td>BSN</td>
</tr>
<tr>
<td>7. Jane</td>
<td>F</td>
<td>22</td>
<td>BSN</td>
</tr>
<tr>
<td>8. Joseph</td>
<td>M</td>
<td>25</td>
<td>BSN</td>
</tr>
<tr>
<td>9. Kristin</td>
<td>F</td>
<td>27</td>
<td>BSN</td>
</tr>
<tr>
<td>10. Matt</td>
<td>M</td>
<td>31</td>
<td>ABSN</td>
</tr>
<tr>
<td>11. Olivia</td>
<td>F</td>
<td>26</td>
<td>BSN</td>
</tr>
<tr>
<td>12. Rebecca</td>
<td>F</td>
<td>23</td>
<td>ABSN</td>
</tr>
<tr>
<td>13. Renee</td>
<td>F</td>
<td>22</td>
<td>BSN</td>
</tr>
<tr>
<td>14. Severene</td>
<td>F</td>
<td>44</td>
<td>BSN</td>
</tr>
<tr>
<td>15. Zelda</td>
<td>F</td>
<td>38</td>
<td>ABSN</td>
</tr>
</tbody>
</table>

BSN = Bachelor of Science in Nursing  
ABSN = Accelerated Bachelor of Science in Nursing
Students enrolled in this study varied in backgrounds, prior experiences, age, gender, and sometimes culture. Each began his or her clinical experience with differing motivations, attitudes, beliefs and values. Those who had prior experiences within the healthcare system, or had responsibility as caregivers, for example, may have begun their clinical experience with a different perspective on caring than someone who had not had those experiences, or, perhaps, had never been in a hospital. In spite of such differences, all students who entered the clinical arena were expected to assume a role for which they were largely unprepared. They would be providing personal, and at times intimate, care to a total stranger in an unfamiliar environment. Additionally, their patients might need complex care requiring extensive professional and technical knowledge. In this context, students grappled with assuming a new professional role and discovering what caring meant to them. With unique backgrounds and diverse clinical experiences, students shared a journey toward a common program endpoint—becoming a caring and competent provider.

**Perspectives on Caring Relationships**

In telling stories of clinical experiences, students recognized and articulated factors influencing their development as caring nurses, uncovering personal meanings about past caring incidents. Joseph, for example, recalled caring for an infant with hydrocephalus whose parents lived a good distance from the hospital and could not visit often, and described what the experience meant to him.

> I was really, really touched [by the situation]. I noticed that he responded to being held. There were a number of times when
I picked him up for short periods of time and I noticed he would relax more and maybe close his eyes. There was one time during the day that I had him [as my assigned patient] that I just sat in the room in the rocking chair and held him for maybe an hour or so just because I felt that was the only way he was gonna rest and sleep. I just sat there. I had to get around all his leads [electroencephalogram leads on the infant’s head for continuous monitoring for seizures] and hold him but it was really good to sit with him and have him rest.

Revisiting past clinical events seemed to make students aware of their changing perspectives on themselves in caring relationships at different points in the program. After they acquired proficiency in interpersonal skills, gained a broader knowledge of nursing, and became more confident care providers, they described forming relationships with more ease, and understanding patients’ needs better. Further, as they improved their understandings of the meaning and significance of patients’ symptoms, and of the gravity of patients’ conditions, they were also able to draw on their expanding knowledge and provide a greater panorama of caring interventions.

Because students could simultaneously hold a later perspective on an experience, and remember the initial experience, they could gauge personal change and acknowledge how their personal and professional growth as a caring nurse had been influenced by earlier
experiences. One student, Renee, for example, expressed her change in confidence in her ability to understand her patient’s needs.

In other [later] clinical rotations, I’ll be like, ‘I think this is what’s going on, and they (staff nurses) would be like, ‘Okay, that sounds good.’ That is something that initially I wouldn’t necessarily feel comfortable about doing--telling them, ‘Hey, this is what I think.’

Specifically, students perceived their views of caring within relationships had changed. Their focus in early stories was on learning about themselves. This focus led them to see caring being expressed, for example, when they could successfully form human-to-human connections with patients. They also saw how their emotional and psychological growth influenced caring as they advanced in the program. And, in later stories, students spoke less about discovering their capability for caring, and more about how caring was embedded in their nursing actions taken to improve a patient’s status or make a difference in a patient’s quality of care.

Students expressed their views on caring narratively through descriptions of clinical experiences, and in statements regarding what caring meant to them. Students gave rich descriptions of how they demonstrated caring in the context of their relationships with patients. These descriptions illustrated students’ diverse and far ranging expressions of caring in a variety of circumstances. The findings in this study are derived from these descriptions. In addition, students’ gave statements articulating meanings of caring. Their statements expand the views students expressed in narrative form. In addition to the quotes within this
chapter, a sample of students’ statements describing the meaning of caring can be found in Appendix J. These descriptions offer insights into the range of students’ beliefs about caring, and enhance understandings of how students believed they experienced caring relationships. They also represent students’ efforts to explicate the concept of caring.

**Findings**

Students shared stories about their growing understandings of the meaning of caring. Initially, they described caring as an inchoate, heartfelt internal state or mindset that motivated them to reach out to patients and want to help them. Their concept of caring was not fixed, however, and students reconfigured their perceptions of caring through formative clinical experiences, gradually developing more elaborate views on what caring meant. They spoke of how they came to understand the central place of caring in their nursing role, and by the end of the program, saw it more as a lynchpin for sophisticated nursing actions taken to serve patients’ best interests.

**The Development of Caring**

The essential experiences in which students gave examples of learning about caring clustered into three broad categories. These categories represented stages on a continuum of learning about caring. Each stage characterized a successive shift in focus. The early stages reflecting students’ abilities to integrate early learning experiences focused on identifying self as being able to care, and on discovering an identity as a caring professional. Later experiences represented in the later stages focused on student progress in becoming more able to act as a caring provider. The continuum represents students’ lived experiences of
learning to enter the complicated personal and illness worlds of patients, and establish a caring purpose for themselves there. The three stages describe patterns of learning at different points from the time students began their clinical experiences until they completed their program. The starting point on the continuum was when students entered the clinical setting with little or no understanding of how their perceptions and insights into patients’ feelings and needs would guide their meaning making about caring. The end of the continuum represents students’ realizations that caring was a substantive aspect of who they were, and perceived its influence in helping them negotiate the complexities of knowing patients, understanding their needs, and addressing those needs with competent nursing care.

The three stages of this continuum represented the constructs learning about oneself, learning about others, and learning to be a care provider. Students described their movement through these stages as having been influenced, in particular, by experiences that challenged them to see themselves as caring providers. Their growing self-awareness centered on recognizing the impact of selected experiences in teaching them to recognize, value and embrace a caring identity in themselves.

**Stage I: Learning About Oneself**

This stage was characterized by student experiences in the beginning of their nursing program, most often in their first clinical course. Students focused, at this point, on discovering how they could express caring towards a patient. They described experiences seeking acceptance by and forming connections with patients. They spoke of these experiences as having been formative for them, insofar as the experiences enabled them to
reflect on their personal responses to learning about themselves in a new, previously untried role. Through these experiences students began to understand the new caring identity they were developing, and to do what was expected of them as caring nursing students learning to function in the context of practice. Students were seeking answers to such questions as “Who am I in this new caring role?”

**Being accepted by the patient.** One of the first concerns of student nurses in trying out their new caring role was how to meet the challenge of acting in the role for the first time. Many students had never interacted with a patient before beginning their first clinical course. Assuming a new caring role was a complex and sometimes uncertain process for them. As they began their clinical experiences, a number of students described how the possibility that patients would not accept them was a common worry that made them uncomfortable and caused them anxiety. They perceived that being liked meant the patient would be open to participating in a relationship. Conversely, students perceived a negative response from a patient meant they would be viewed as not being liked. They saw patients’ perceived negative attitudes as having the potential to become barriers for them in forming relationships.

One student, Holly, provided a perspective on students’ initial experiences with being accepted by a patient. “Whether or not the patient likes you definitely affects how that person receives [your] care. I feel like hoping that the patient will like you is kind of a big part of it.” Isabella also spoke about being accepted, mentioning her fears that her patient might not welcome her as a care provider. “I was nervous to tell the patient I was going to be his
nursing student. I was thinking, ‘Are you going to accept me?’— ‘cause I’m not really a nurse yet.” Another student, Isabel, spoke similarly about being uncomfortable trying out her new role.

In the beginning I was scared to even go in the patient’s room. I was nervous about bothering them. I would go and kind of be like, ‘Oh, let me do my assessment and just leave.’ But I’ve come to realize that patients enjoy when you’re there, [enjoy] talking to you. I take more time now to talk to the patient, getting to know the patient more.

Seeking acceptance was also a theme in Jane’s story. She spoke of how she tried to find a way to initiate a relationship with a particular patient. Jane found herself experiencing anxiety and fearing rejection from a patient, which the nursing staff had described as difficult and demanding. While Jane wanted to be caring and empathetic, her fear triggered negative feelings in her about the patient. Jane believed if she did not see the patient in a positive light, her ability to communicate with him would be compromised. She tried to override her unwanted negative perceptions by replacing them with caring, non-judgmental ones.

When I introduced myself to my patient, . . . I had already prepared myself for what I thought would be a ‘difficult’ patient. From reviewing his chart, I learned that . . . he was hospitalized after undergoing . . . gastric bypass surgery and had multiple complications of morbid obesity. The patient’s wife warned me that he was often very ‘grumpy.’ The nurses
considered him difficult and demanding. All of these details converged into a decidedly negative preconception of my patient.

. . . I was just unsure going into the room what to expect.

Discomfort with her fear of non-acceptance motivated Jane to strategize about how to reframe her perspective. She explained, “Well, I think more than anything just going in there was kind of – I was trying to be as open-minded as possible, and spending time with the patient and with his wife and just kind of getting to know them.”

Jane was able to accompany the patient to a radiologic procedure where there was a turning point for her in her efforts to establish a connection.

Seeing this tiny little stomach I was like, ‘Oh my gosh that — it’s just a little bulge off the esophagus, and I was like -- you have to see this.’

And I think the patient, he could see it as well. . . . (Laughing) . . . [I told him}, ‘you are going to lose weight — things are going to happen for you and you can do this.’ I don’t know -- it was just really positive . . . and I think it really was something that bonded us.

But even just having a chance to sit down there. . . . We had some time to just talk. I think that getting to know one another . . . that laid the foundation for a good working relationship between us.

Her experience with this patient was foundational for Jane. When asked how the experience had influenced her, Jane pointed out its importance.

Well, I think this situation really does [have a long-term influence].
That is always my focus with my patients – it is that relationship with them. I think this situation definitely reinforced how important it is to establish that relationship with the patient to enable them to make changes in their life.

**Forming connections.** Learning to form a connection with a patient was the second aspect of this stage of learning. With experience, students were more able to communicate with patients, and expected patients would welcome them. Their stories were no longer about their anxieties over first time encounters. Students talked instead about the importance they placed on expressing caring by forming connections with patients. While students spoke of feeling insecure in their knowledge of nursing, and of still feeling uncertain about how to relate to patients, they nevertheless seemed to find validation of a caring identity in valuing patients and in making human-to-human connections with them.

Themes of caring as a part of connecting with patients resonated in their stories. This awareness of self as caring seemed to help them in their ongoing work to develop a sense of the meaningfulness and importance of their role. In their stories students talked about how seeing patients as more than an illness helped them to form connections, and further grounded them with a sense of having a caring purpose. In making connections, it seemed, students were trying to communicate to patients that they valued them as human beings.

As in Jane’s earlier story, students spoke of finding ways to relate to patients that involved connecting with them and getting to know them. The process of forming a connection and discovering the significance of it to one’s learning, like all student learning,
was deeply personal and contextual. However, students not only perceived making connections as caring behaviors; they also saw connections as first steps in building relationships based on responding to a patient as more than an illness.

Students connected with patients in unique ways. Yet their stories were thematically similar in implying that the person, not the illness, was the most important element in making connections meaningful. Beth, for example, talked about a woman who was “probably the patient [she] got the closest to and established a close bond [with].” The woman was a surgical patient, and Beth took care of her for two days early in her clinical experience. She remembered the experience as “my first time going into a patient’s room by myself to introduce myself.” She said that she felt overwhelmed because there were many visitors in the room. But the next day, only the husband was present with the patient, and as Beth says, “we talked about life and I got actually really close. I still talk about them [the couple] with my friends.”

Interestingly, although Beth emphasized the importance to her of forming a connection with this patient, what she remembered most about the experience was how the patient got dizzy and almost passed out, and how, in the uncertainty of the moment, she “lost sight of the interpersonal aspect of the relationship” and focused on the “science of it.” Beth was struck with the realization that she did not first try to help or comfort the patient, but, as a novice nurse, “forgot that there’s that piece to her, like she’s a person before she has all those things. I didn’t think of that emotional part of it.” From Beth’s experience she learned how much she valued the caring aspect of her role. Her story illustrates what she and other
students came to realize: that they were acquiring knowledge and skills, and had been prepared through course work for clinical experiences, but had not had many opportunities to apply what they knew. And, while, like Beth, many students might not have felt prepared to handle unanticipated changes in patients’ conditions, they nevertheless found making connections a meaningful part of what they were learning as a nurse.

Another student, Renee, illustrated this point when she commented, my physical skills, like my assessment skills, and my actual nursing care skills, they had a lot to be desired, which developed over time. But the interpersonal part of it, I think it needs to be there from the beginning and then you can only hone it. So it made me aware that I have the interpersonal part and eventually I’ll get it [all].

For Carrie, too, seeing the patient as more than an illness, and then connecting with the patient, gave her a sense of purpose in this early stage of learning. In talking with Carrie, I learned a fundamental aspect of how she, too, viewed the purpose of her relationships: to see patients, not illnesses. She illustrated her perspective when she spoke of how she reached out to her patients.

Like they are still important, still important outside of their disease or sickness . . . Caring for patients is making sure they know they aren’t just a heart problem. They still have strengths and they still have things they like to do . . . When I was talking with an older woman who was like . . . she could barely walk anymore.
She could barely hear. But she loved watching *The Price is Right*.

She just loved watching that . . . So for her, caring was sitting
down and watching with her for a little bit.

A number of students described specific challenges they faced while trying to make
connections. A typical situation described by some was feeling overwhelmed by the
perceived challenges of taking care of seriously ill patients. Novice students saw seriously ill
patients as having complex needs. These patients might be non-responsive because of a
stroke and be unable to communicate with the student. Or, a patient might have multiple
medical problems and the student would not be able to understand the relative importance of
each problem when planning care. Given their limited experiences, students might also find it
intimidating to care for patients who were supported by extensive technology.

While these types of patients required complex care, staff nurses assumed
responsibility for addressing the full range of the patient’s care needs. The nursing student
was responsible for providing basic personal care. Nevertheless, to a beginning student, these
kinds of patients could be seen as threatening. Perhaps this was because students feared they
would not know how to connect with the patient, or, perhaps, due to inexperience, they
thought they might possibly harm the patient. Experience caring for seriously ill patients,
however, could be formative for students because when students assumed care of one of
these patients, they quickly learned they could not only provide the basic care the patient
needed, but also make a caring connection in a way that was meaningful to them.
Kristin shared her feelings about making a connection with a patient she initially perceived would need care beyond what she was able to provide. She offered this insight into what she learned from the experience about the importance of her caring role.

You had to go in and do it. I had to kind of psyche myself to go in there, but . . . as soon as I went in there and you actually see a human being, and you see someone that really needs your help . . . All I thought was, I would want someone to be caring for my grandmother, my mother, my family member in the way I was about to go ahead and do that. So everything else kind of fell away when I realized she really couldn’t help herself and I needed to be there.

Rebecca, another student who had a challenging experience with a seriously ill patient, talked about how the experience led her to a personal understanding of the importance of finding a way to feel connected even when she perceived the patient’s illness was a barrier to connection. Rebecca struggled to understand what kind of care would convey to the patient that she was valued and respected.

Rebecca’s patient was very sick and did not talk to her. Rebecca was unsure of how to relate to the patient as she had never before provided care to a patient who was not fully alert. Further, she did not grasp how ill the patient was.

So I go into her room. You know, introducing myself as the student nurse that day. She’s not opening her eyes. I could never get her to
open her eyes. And when I went in the room you could hear
her breathing—like she was having such a hard time breathing. It
didn’t look good, I guess. The day before they had told me that she
was going to be on palliative care. And I was like, okay. I’m a new
student. I didn’t exactly know what that meant. So I didn’t know if I
was just going to walk in her room [and something would happen] – or
that she would pass away months from now – just kind of the whole
palliative care thing. I didn’t know what that meant.

Rebecca continued to describe how she responded to the patient in spite of the
patient’s inability to communicate with her.

My most significant memory [about the experience] was that when
I was bathing her, . . . she hadn’t really opened her eyes all
day. And she hadn’t done anything to make me feel like she accepted
me. . . . I’d been told that you’re always supposed to talk to your
patients because they probably hear you. . . .When we started giving
her a bath—you could tell her body was all tense. You could tell she felt
uncomfortable and didn’t really know what was going on. Even though
maybe she could hear us, she didn’t communicate. So I stopped and I
held her hand—and I kind of remember—like I was rubbing her arm
a little, and I called her by name, and I just said, ‘We’re trying to get you
cleaned up. We’re giving you a bath. We’ll do it as quickly as possible.’
And because I directly said those things, she kind of relaxed. I mean she opened her eyes once when she was tense and got scared, but then she just relaxed and let us give her a bath.

Rebecca’s patient passed away the night after she cared for her. In reflecting on the situation, Rebecca shared how the experience influenced her throughout the remainder of the program. She felt she learned the importance of being caring and compassionate. She believed that it was important to always show patients that you were really taking time with them.

Rebecca’s reflection illustrates how each student’s experience is deeply personal. Because of her beliefs about caring, she was able to show empathy for the patient, even though there was only one-way verbal communication. She acknowledged that the patient’s feelings needed to be validated even though the patient could not articulate them. Through this experience, Rebecca learned a lot about herself. She learned she could make a connection in a way that was meaningful to her, and that she was able to find a caring purpose by showing respect and preserving patient dignity.

Formative experiences in seeking acceptance and connection were important to students in learning about the many dimensions of caring. In the process of learning about oneself, each began to understand how he or she was affected by expressions of caring.

**Stage II: Learning About Others**

Over time, students assembled a broader composite of experiences leading them to develop a more comprehensive picture of a caring identity. Having found a sense of caring
purpose in valuing patients and in making caring human-to-human connections with them, students suggested that they entered a second stage on the continuum of learning about caring. In this stage—Learning About Others--student learning was less focused on themselves and more on learning about patients and their problems and needs.

A key characteristic of learning about others was discovering the importance of having a reciprocal relationship. A reciprocal relationship involved mutual respect and valuing between patient and student. It implied each trusted the other. In this relationship, patients’ welcomed students as care providers and also valued them for their contributions. Students, in turn, accepted and respected patients for who they were as individuals. They spoke about patients as people who had lives and histories beyond their illness experiences.

Another characteristic of learning about others was being valued by and having the respect of the nursing staff. Students tried to establish themselves as credible care providers in the eyes of the staff, and nurses generally showed regard for students’ judgments and observations of patients. However, in this stage, students noted that staff nurses did not always listen to their input. Nursing staff could create barriers to student learning when they were not attentive to the information students provided to them about their patients’ conditions. In their stories, students revealed how not being heard could have an impact not only on their learning their caring role, but also on the patient. Further, when nurses ignored their input, students experienced self-doubt about their abilities as care providers.

**Developing reciprocity.** Patients entered into reciprocal relationships with students with an understanding and appreciation of students’ efforts to help them, and a trust that the
student would provide effective care. When appreciated, students felt they could better align themselves as partners with patients in stronger, more caring, student nurse-patient relationships. Reciprocal relationships signaled deeper involvement from students as patients, feeling accepted by them, openly expressed positive and negative feelings. Knowing more about a patient as an individual and about the patient’s illness gave students opportunities to understand care needs and negotiate care with patients.

This reciprocal relationship was especially meaningful to students because it allowed them to be authentic in their caring role. When patients accepted them, students were assured they could be themselves. Being authentic meant to students that they did not feel they had to be seen as being fully competent, or to feel inadequate when they were not. Even if they felt their contribution was not equal to that of a staff nurse, they nevertheless felt confident that the care they could offer, albeit circumscribed by their scope and capabilities, was nonetheless important and real, and that it made a difference for the patient.

Reciprocity in a caring relationship was implied in many students’ stories. In one story, Kristin provided an example of being valued by a patient. Kristin talked about what happened in her relationship with a patient hospitalized with cystic fibrosis.

I just kind of talked to her as a . . . person who might be sad for being in the hospital for a long time. [I] just started talking to her about her disease but also her family. . . . She just let it all go. She talked to me about her daughter and her husband . . . and how she really wanted to get better for her twelve year old daughter . . .
I realized that was what she needed. She just wanted to sit there and cry. She was someone who appreciated it and thanked me multiple times.

In another story of a caring relationship, the patient was equally welcoming, and reciprocal. Renee talked about how she connected with her patient by acknowledging the patient’s individuality, and recognizing the broader dimensions of the patient’s life. Renee’s story is an example of how students perceived relationships to be caring if the patients reflected back to them that they needed and wanted their care.

Honestly, I think what stood out to me is I was able to talk to her just like all day . . . so I know I talked about pain management for her and I think not being the one to give the meds kind of enabled me to just listen to her and kind of be with her the whole day. . . Also, advocating—especially the second day that she get her pain meds on time . . . other than that, just talking to her. She was one of the first women to work in the IT Department; she traveled to India and London and like all these different places. So we just spent time talking about her choices when she had been growing up . . . So it was cool just to talk to her as a person and get to know her.

Lastly, Carrie’s story provides an example of how, in a reciprocal relationship, a student, like Carrie, felt like she could be herself, that is, a novice who was still learning how
to provide care. Carrie’s story was about her experience with a maternity patient who was close to Carrie in age.

On OB [obstetrics], one of my first patients was very young. She was 19, so a little bit younger than me. And even though the fact that she was pregnant and having a baby and I’m in school, we just formed a really easy connection and were able to talk about . . . simple things like make small talk a lot. I feel like I formed a connection with her because she was very comfortable in asking me questions and very open . . . She talked to me and I was like ‘You know what? I’m learning things as you’re learning things, so you tell me if you have any questions and I’ll ask you questions like does this hurt and please tell me the honest truth’ or like ‘Do you have any questions about how to swaddle your baby and we can learn it together.’

Being in relationships where patients welcomed and appreciated their care provided valuable learning for students and affirmed for them the authenticity of their caring role. But reciprocity was not a static condition. Relationships varied in the mutual contributions by students and patients, and reciprocity was sometimes elusive. Students learned that in many relationships patients did not openly reject them but also did not really seem to value what they were doing either. Students shared insights into how they were learning about the
intricacies of interpersonal relationship with patients, and began to talk about how they perceived their caring could be different for different patients.

In another experience Carrie shared, she spoke of being with patients who “were never rude,” but with whom she did not perceive she was able to make a meaningful connection. Carrie could not make a connection with some patients “because,” as she pointed out, “the patients didn’t validate my need [to be taken seriously as a nursing student].” Carrie’s experience echoed those of other students when she spoke to what it was like when patients did not appreciate her efforts to be a care provider.

Some of it was that they didn’t validate my need. They were like ‘Oh, we understand our medications. We’ll save our questions for the doctors. You do your thing.’ They were never rude to me and never would have kicked me out of the room or anything. But . . . some [patients] just didn’t give me a sense that my role was meaningful to them.

Matt shared his perceptions of working with patients who were not forthcoming in communicating reciprocity. Like other students, Matt thought he cared for some patients more than others. He did not think he was caring in the same way when patients did not accept him as he was when they communicated that they wanted and appreciated his care. Referring to patients who welcomed him, Matt said, “Some . . . you’re just gonna care more about.” Matt implied that it was just easier to care for patients who liked having you as their
nurse. And, Matt told how challenging it could be for him to be with a patient who just
couldn’t participate in a caring student nurse-patient relationship.

I feel like just them being that difficult increases that divide—
where maybe you don’t want to walk in that room every time you
pass it. You start to break down that obligation you feel. I mean
I had to check myself a couple of times. You start to get really
frustrated and think, ‘This can’t be my job.’ But then I think, ‘Well,
it kind of is.’ I don’t wish them ill or anything. They’re still going
to get care. I think . . . it transforms me having to be more
understanding, so I try. I have to dig a little deeper to get that
empathy. . . .They’re stressed out or they’re scared. There’s a
reason for it. It’s not that they’re horrible people. . . . I mean,
you can’t really know. So you have to try a little harder to
understand that ‘Okay, she’s having a rough time.’

Holly shared a similar perspective on relationships she had had with some patients,
but conveyed more of a sense of how building relationships that were reciprocal was a
mutual process requiring negotiation on the part of both student and patient. Like Matt, Holly
found caring relationships sometimes confounding, and the student role unclear and
equivocal.

There’s a strange relationship that happens. I think it is strange
because you want to like them and you want them to like you and
at the same time it’s supposed to be a professional relationship. . .

You know it is a nurse-patient relationship. But in the moment, you’re trying to be friends with that patient to get along with them, so that they will accept your care.

**Being respected.** Caring relationships were best supported when students felt they were in safe places to practice what they had learned. In order to feel safe, students needed to be respected by the nursing staff. When the nursing staff accepted students as future colleagues, students believed they met the staff’s expectations and were respected. Thus, being respected was an affirmation of their caring identity and ability to contribute to the care of patients. In talking about being respected by staff, students noted the negative cases as significant for them. They described feeling a loss of self-esteem when nursing staff ignored their observations about the condition of their patients. These students shared stories about how nursing staff’s disregard for their contributions created ambiguity about their caring role and undermined their confidence. At times, they said, not being heard also made them feel anxious concerning the condition of their patients. Because of this disrespect, students felt thwarted and unsure in their interactions with patients.

Matt shared how he was uncertain about his role when he identified a patient’s irregular pulse as abnormal. He told the patient’s nurse, but she did not do anything or provide Matt with any feedback about the significance of this abnormality. This lack of feedback created ambiguity for Matt, and he was unsure of how to continue with the patient’s care. Thinking he might be the only one concerned about the irregular pulse, he
was afraid he might embarrass himself if he made “a big deal over what might be nothing.”

Yet, he did not want to ignore the finding, and possibly compromise the patient’s care.

Although he wanted to follow the lead of the nurse, without additional information, Matt was unsure of the right course of action to take. Eventually he confronted his self-doubt and sought out his clinical instructor. Together they investigated the patient’s history and learned that her irregular pulse had been long-standing and was not an acute problem needing attention.

Like Matt, other students spoke of being confounded by their sense of being devalued when nursing staff did not respect them and their contributions as care providers. Another student, Zelda, shared her experience of lack of respect from nursing staff. Preparing to provide care to a patient with multiple wounds, Zelda had researched the patient’s chart and identified five wounds. When she and the patient’s nurse listened to the report of the night shift nurse, only four wounds were discussed. Knowing a missed wound meant a wound would not be examined and a dressing change not get done, resulting in possible discomfort to the patient and a risk for wound infection, Zelda spoke up about this discrepancy. However, when Zelda raised an issue about the fifth wound, the nurse disregarded what Zelda said. “It really bothered me that I let someone else override what my research told me was probably the right situation. I think I deferred to her judgment because she’s in a higher position power-wise.”

It was not until the end of the shift that Zelda realized that she was right: a wound had not been evaluated. Zelda described her feelings of guilt for not having lobbied more strongly
for what she knew to be true. Because she had not spoken more forcefully, she believed she had violated her own values in not providing the kind of care the patient needed, and had let the patient down. In reflecting on the experience, Zelda conveyed how she perceived her behavior and how it affected the relationship.

I think what made me feel real bad was that he was in some discomfort from the wound that he had, and it’s something that could have been easily addressed. I felt guilty that I had allowed [the nurse] to kind of not really bowl me over, I guess, but just kind of intimidate me into not pursuing it further. Because it wasn’t just an issue of me and my feelings, but it was an issue that impacted the patient. He was uncomfortable. You know, I think he felt—he didn’t feel like he could trust me to provide good care—at least I felt that way.

In learning about others students focused on the dynamics of building reciprocal relationships. They also learned how staff nurses could influence them in their caring role. Students learned to see themselves as capable providers through the variety of experiences they had in myriad patient care situations. In facing challenges to developing their caring role, students learned how they, and the patient’s care, could be affected, and how their caring identities were being reshaped through a process of personal and professional growth.
Stage III: Learning to be a Care Provider

Learning experiences in the third stage of learning about a caring role occurred as students approached the end of their program. Students shared how in this stage, caring was characterized by a sense of competence. Through stories, students expressed feelings of being effective, being empowered, and, in general, expressed how they were able to assume greater control of patient care. In this stage there were three elements of learning that related to becoming a care provider. These elements included becoming better communicators, becoming patient advocates, and acting as a caring professional.

**Becoming better communicators.** In this stage, students perceived strong communication skills to be essential in developing and maintaining a caring relationship. Kristin, for example, summed up the beliefs of many students about how communication was fundamental in relating to patients. She talked about how long it took her to realize that “in nursing school you’re set up to know all this stuff [you learn in lab]. You’re constantly evaluated on it. And you think, ‘How am I ever gonna do all this stuff?’” But then realizing finally towards the end [of the program] that being able to talk to people is just as big as the stuff [the nursing knowledge and skills].”

Another student, Isabella, believed communication was central to a caring relationship. She commented about an “aha” moment when she realized,

There’s so much more to the patient than their admitting diagnosis and their medical history. There’s a lot more going on with patients. The more you get to know them, the more you can understand their condition first of all,
and then also be there to understand what they’re going through. Then you can be there to help. . . kind of ease the situation as much as you can for the patient. It forms the nurse-patient relationship that I like about nursing.

Isabella believed that “the more interaction you can have . . . the more trust you can develop because they [patients] open up to you more . . . They will tell you more things and that will influence their care.”

Olivia echoed the belief that good communication, either verbal or non-verbal, was foundational to acting as a caring professional.

Listening, to me, is the cornerstone of caring because if you can do nothing else for the patient, you can listen to them. And if you can’t listen to them because they can’t speak to you, you can be present with them. So… I’ve taken care of some patients who had tracheotomies or ventilators and couldn’t really communicate, but I found a way to communicate with them by blinking their eye or squeezing my hand. But even just being in the room with them and making them feel like a valuable human being is a critical piece of caring in the hospital especially because I imagine that patient can very easily feel like another task or another number.

**Becoming patient advocates.** Although students talked about communication primarily as a process in support of a caring relationship, students also saw how effective communication with patients was important in helping them be patient advocates. The more
attentively a student listened, the more information a patient shared about who they were and what they needed. In stories about themselves in the role of advocate, students described having a good understanding of what the patient needed, and the confidence and capability to effectively act on behalf of the patient to meet their needs. The stories are important because they exemplify how advocacy can be an aspect of caring. Each of the following stories reflects a different context of advocacy by the student nurse.

Isabella, who had been providing care for a patient who had had a stroke and had expressive aphasia, noticed that the patient “took a long time to get out small words—couldn’t form sentences very well.” She realized the patient had a lot to say and she needed to give her a chance to “get it out.” Isabella learned that the patient was concerned about the development of a tremor and why it happened. When the patient, because of her aphasia, was not able to express herself well when the physician was present, Isabella spoke to the physician on the patient’s behalf. The physician then provided the information the patient wanted.

In another story, Kristin spoke of how she saw an opportunity to advocate for a patient who was a prisoner. She talked about how the patient “was so appreciative of everything [she] did for him.” Noting on his chart that he had not been out of bed, Kristin asked him if he wanted to walk. He replied, “I haven’t gotten up and walked in the six days I’ve been here.” And Kristen thought, as she said, “Well, maybe we can work that out.” She undertook walking her patient in spite of the fact that he had to be handcuffed, had a chain
around his waist, and had two guards walking with him. At the end of the shift, the patient
told Kristen how grateful he was for the extra effort she had taken to provide his care.

Severene advocated for a patient’s family when they did not understand that their
loved one was going to receive palliative care.

I was in the room, I was working with IV pumps, I was talking to
the family, getting to know about this man [the patient had gone
for a procedure and wasn’t in the room at the time]. While I was there
I got to know the family. They began to be more comfortable with me
and they started to ask me a lot about what was happening to their
loved one. They were concerned and they felt like they were in the
dark. They said ‘we’re not sure what’s going on.’

And so right away I found the doctor and my preceptor said
go ahead and let her [the doctor] know what was going on [with the
family]. You know, that the family of Mr. X approached me and
wondered if he is supposedly dying. And if that is the case the family
would like to know what his options were. At that point the doctor
said, ‘What!’ How could they not know that he is dying.’ . . . And then
the doctor went in the room. I stayed out and when I went back into
the room later everyone was crying. So I knew they had received the
information they needed. Later in the day they said ‘We thank you so
much. We so appreciate what you did.’
When students were able to see that their advocacy made a difference for a patient, they talked about themselves as empowered care providers. Holly, for example, had an important experience with a patient in the intensive care unit. This patient had been given the option of palliative care. Holly helped the patient clarify her understanding of her care options and provided advocacy to the multidisciplinary team for the patient’s wishes.

I was able to sit in on a lot of those palliative care conversations. I don’t think I’ll ever forget those. After they [the palliative care team] talked to her [Holly’s patient] about her options, my preceptor and I talked to her as well and she said, ‘I want to fight. I want to be here.’ She wanted a full code. That’s what she decided for herself. We had a very long conversation with her about ‘If you want to fight, then you have to help us help you fight. You have to help us. . . you have to let us turn you. Refusing meals is not gonna help you heal,’ and all those things. Having that conversation [with the patient] is what made it nursing for me.

Although caring was implied in students’ stories of advocacy, Isabel expressed how she saw a direct relationship between caring and advocacy.

I feel like caring is the center of what nursing is. Everything we do is caring for the patient. And definitely patient advocacy. Being that advocate, I guess shows that you care about the patient because you want to do what’s best for the patient. It might not be what the
providers or what everyone else thinks is the best route. But I
guess sometimes being an advocate is recognizing what the patient
wants...  

**Acting as a caring professional.** There were two aspects of learning that had a key
influence on acting as a caring professional. They included learning to handle emotions in the
clinical setting, and observing role models who provided students with perspectives on how a
nurse could act as a caring professional in complex patient care situations.

**Handling emotions.** Although earlier stages included a focus on students’ emotions,
at this stage, students had a heightened awareness of how patient care situations could
generate unexpected and at times, difficult emotions. In some stories they talked about how
they came to understand that acting as a caring professional meant learning to manage
emotional responses. Students tried to avoid being confounded by their feelings while giving
their attention to caring for patients. For example, they were learning to become close to
patients in order to have authentic caring relationships; they were also developing the
emotional maturity to keep a respectful distance in order to maintain objectivity. As Holly
noted...  

Despite all the knowledge-based preparation a student can
complete prior to entering a patient’s room, it is difficult to be
truly prepared for the emotional experience of caring. I think
... you go through the experiences sometimes [of interacting with
patients] but I don’t think we realize that we have our own emotions
that are associated with our experiences. When she [patient] kind of lashed out at me, I . . . felt personally hurt and I didn’t realize that would be a part of my response at all. I never expected that I, myself, would be emotionally involved in that situation. I think there are emotions on multiple levels, like very deep-seated emotions that . . . come out in care that I don’t think we’re conscious of.

Although students described themselves as being challenged to learn to deal with their emotions in different contexts, caring for patients in the intensive care units in their final semester provided some of the greatest challenges. Being placed in an intensive care unit sometimes meant students had to confront significant, debilitating medical conditions, as well as dying patients and their families. Two students, Beth and Holly, spoke of emotionally demanding experiences surrounding the care of their patients in the intensive care unit. Both of their stories illustrate the difficult path students sometimes have to negotiate in processing what can be painful emotional experiences. For Beth and Holly, these experiences were important in helping them come to deeper understandings of the meaning of acting as a caring professional.

Beth’s story was about an experience she had while caring for a patient in the neurological intensive care unit.

I’m in the neuro ICU and you see so much. Most of the patients are sedated. . . . Like I care for them but I feel like I’m more [focused on] the family. I think that’s harder. I was telling a nurse the other
day, I was like . . . ‘it might sound insensitive but I don’t feel so much sympathy for the patients as I do the families.’ . . . I remember last week I was on the verge of tears seeing my patient and her husband. Her husband was talking to her and she is . . . she’s sedated and she’s been out of it for a few days. It’s a big shock to the family and her prognosis is bad, but the husband keeps talking to her and it’s just like . . . it was so hard to watch.

Holly, too, shared an experience of intense emotions associated with witnessing the death of a patient for the first time. Holly’s patient had been on the ventilator for some time and was not improving. After conversations with the physician, the family decided not to continue with life support.

The whole situation was very fascinating to me, because I didn’t know what to do. I mean, she’s dying but she’s not very responsive. I mean, they always say hearing is the last thing to go, so maybe she could have been hearing what was going on around her. It was just . . . I didn’t know what to do. I’m sure in that last hour of her life we had seen . . . I saw so many weird things in her vital signs and we’re not doing anything about it. We were giving her morphine as was necessary to keep her comfortable, so she’s not labored for breathing and all of those things. . . The whole situation was
very fascinating to me because I didn’t know what to do . . .

That’s the first time I have been in a room while we’re watching this patient die.

Holly noted, “I think it’s . . . hard as a student being in that situation of [with] experienced nurses. I was the only student on the unit. So it’s not like while I’m at my lunch or while I’m at my break I can kind of vent to someone else about ‘Something weird is happening and I don’t know how to deal with it.’” She noted her difficulty in responding differently to death than the experienced staff nurses who “had seen that in the past and dealt with that in the past.” Holly shared, “Everyone’s pretty laissez-faire about what’s happening. You know. Like having conversations outside of the room as if it’s just a part of the day. I’m sure it is part of the day, but . . . it was hard for me to even . . . for me to even try to talk about it.”

Experiencing strong emotions in the clinical setting was a common narrative thread in many stories. Students recognized the important influence their emotional responses had on their personal and professional growth.

**Observing role models.** Learning from role models was another key influence in helping students assume their role as a professional caring nurse. Students shared examples of how role models had a powerful impact on their learning. Role models were most influential, in particular, when these student nurses found themselves in situations where their efforts to be caring were ineffective. The role models to these student nurses
demonstrated how to communicate caring and understanding to patients in ways that had not occurred to students.

Severene, for example, talked about learning from a staff nurse who was able to connect with a patient when Severene was unable to do so. In this story, Severene shared how she had been working with the patient, an elderly woman, in the neurological intensive care unit.

I had worked with her for weeks. I got to know her quite well.

I saw her from the point when she first came in—she was talking in the ED (emergency department) and then she deteriorated. She was very interesting -- in that she understood everything we were saying to her, but she would refuse to do our neuro assessments every hour. At first I thought she wasn’t oriented, and I told my preceptor I just can’t get her to participate in this neuro assessment. And Gertie (the preceptor) came in and it took her 20 minutes and the patient stated her name, where she was and the year. And this happened over and over. She kind of put her head down on the bed and kind of cajoled her. . . . This Haitian nurse got her to say her name and the things that we needed to know that she was oriented—that she was with us. . . . And it was over time that I started to realize that I needed to talk to her [the patient]. I would just share some things about my day or ask her questions, and eventually she would
chime in.

Needing assistance from an experienced nurse to learn how to act as a caring professional was a common theme in many student experiences. Matt, however, shared an experience in which he needed assistance, but one nurse’s actions left him feeling uncertain about how the nurse’s behavior influenced his beliefs about caring. Matt’s story was about not knowing what to do in an acute situation. His intensive care patient, who could not speak because of a tracheostomy, became upset. Frustrated at not understanding what she wanted, and seeing the patient’s vital signs escalate, he got help from a nearby nurse.

. . . so the charge nurse came in and he just prepared some PRN [as needed] Ativan [an anti-anxiety agent], pushed it [administered it intravenously], and she [the patient] went back to bed [to sleep]. . . . I never figured out what this woman wanted. . . . I’m not gonna drive myself crazy guessing. It was really disturbing to me though that she was looking at me with a frantic look in her eyes and I had no idea . . . and she couldn’t use her hands, it wasn’t like she could write. But it was really scary to not be able to respond to her . . .

But apparently that was also a lesson for me in the culture of that ICU. . . . If they’re waking up, then they probably don’t need to be on that floor anymore. That’s what my preceptor told me.

He [the preceptor] wasn’t concerned one second about what she was
trying to say.

From my perspective, I was like ‘Oh, this is kind of disturbing,’ but they deal with it all the time. And I think I wrote some kind of paper. . . .It was probably a weekly journal about that experience that from day one here, we’re told ‘Listen to your patient. That’s the best form of assessment and only they can tell you.’ I mean this is supposed to be really important and I guess some places it’s not that important.

For most students, role models provided them with new perspectives on caring. Matt, however, viewed the nurse’s actions as equivocal. Students acted as caring professionals because they learned how from their classes, instructors, and other nurses. Sometimes this learning occurred in challenging situations. Observing role models, whether perceived as effective, ineffective, or equivocal, provided opportunities for learning, because students, like Matt, could be challenged by them to reflect more deeply on who they were becoming and on who they wanted to be as caring professionals.

In talking about their learning in Stage III, Acting as a Caring Professional, students shared that they were able to improve their ability to form and sustain relationships because they were more confident in their role, had greater nursing knowledge, and had improved communication skills. In this stage, students had moved beyond the perception that caring required only a reciprocal relationship, and could now refocus their responses away from self and try to better understand the patient’s experience. Students could suspend their need for
affirmation from others in order to feel like a caring student nurse, and assume a care
provider role of greater dimensions. Although students still talked about experiencing fear,
uncertainty, and a need to be circumspect, these feelings were often associated with a more
realistic appraisal of their ability to act in situations in which patients were at risk for possible
harm. During this stage, it was common for students to see patients as vulnerable and in need
of an advocate. This perception was different from earlier stages where these students viewed
themselves as effective primarily when the patient accepted their care.

Also at this stage, students continued to learn about caring but with fewer anxieties
and uncertainties about their caring identity. Learning about caring was often tied to learning
from experiences in which they had had to deal with difficult emotions. Learning from role
models was also an important influence on developing a more caring approach in difficult
patient care situations. When students spoke of role models, it was usually in stories about an
encounter that presented them with a challenge they could not meet or a problem they could
not solve themselves.

Overall, in this stage, students suggested they came to new understandings about who
they were as caring nurses and about how they were able to act in a caring role. For them,
caring was no longer only an internal state; it now permeated many nursing actions. Students
talked about how caring influenced their relationships with all patients.

Summary

Students’ stories in this study revealed their interpretations of and reflections on
experiences in caring relationships with patients. Changing understandings of what students
could accomplish for patients through caring relationships were a common narrative thread that emerged in students’ stories as they progressed through the program. An analysis of the stories suggested that caring was an important influence in helping students form, develop, and maintain relationships.

Through experiences in successive and changing clinical contexts, students explored the meaning of a professional, caring identity. Greater involvement with patients enabled them to deepen and broaden their understandings of the scope of a caring relationship. The more they engaged with patients, the better they understood patients’ needs and expanded nursing activities associated with their caring role. Over time, students augmented their early perspectives on caring with more thoughtful ones associated with greater experience.

Three related stages on a continuum of learning about caring were identified. These stages were learning about oneself, learning about others, and acting as a caring professional. The stages of learning encompassed ways students developed in caring relationships through formative clinical experiences. Factors and conditions affecting expressions of caring, perceptions of self as a care provider, and nursing activities within caring relationships were discussed. The importance of being valued, of finding a purpose through connection, of competence in developing caring relationships, and of becoming a patient advocate resonated throughout the data.
CHAPTER FIVE: CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Introduction

This qualitative, descriptive study used a narrative case study methodology to explore the nature of undergraduate nursing student caring in the context of student nurse-patient relationships. The study was conducted with nursing students enrolled in a baccalaureate program at a major university in the southeast. A purposeful sample of 15 junior and senior students participated in the study. Participants were enrolled in a clinical course in either the school’s traditional Bachelor of Science in Nursing or in the accelerated Bachelor of Science in Nursing program. By analyzing stories in interviews and critical incident papers, perceived characteristics of caring and students’ understandings of the meaning of caring in relationships with patients were uncovered. The research question that guided the study was: How do nursing students experience caring relationships with patients?

Jean Watson’s theory of human caring (Watson, 1999), a relational theory of nursing, served as the conceptual framework for the study. The theory stresses relationships as central in defining nursing and articulates caring attitudes and caring actions. According to Watson, humanistic values and altruistic feelings support the development of caring relationships. In these relationships, patient and nurse share a common bond of knowing each other in ways that transcend individual ego boundaries. In being with the patient and in experiencing moments of connection, nurse and patient create a helping alliance that enhances the life of each.
Watson explains how key concepts in the theory provide architecture for caring relationships. The concepts include the transpersonal nature of relationships, caring encounters, and *caritas* processes. These concepts make explicit what is fundamentally important in a caring relationship. Watson emphasizes how in caring for others, the nurse expands her capacity to care for self, and stays open to “new discovery of self and other” (Watson Caring Science Institute, n.d.).

Although it is difficult to relate concepts such as transpersonal care and caring encounters to lived experiences in caring relationships, Watson guides practical implementation of the theory through ten *caritas* processes. The processes include, for example, “[to] promote and accept positive and negative feelings as you authentically listen to another’s story; [to] be sensitive to self and others by nurturing individual beliefs and practices” (Watson Caring Science Institute, n.d.). Additionally, specific actions that support caring are included as *caritas* processes. Some of these actions are “Assisting with basic physical, emotional and spiritual human needs,” and “Creating a healing environment for the physical and spiritual self which respects human dignity” (Watson Caring Science Institute, n.d). The ten *caritas* processes are presented in chapter two.

This chapter will summarize the findings of the study, and present key conclusions and implications for theory, practice, and research.

**Summary of the Study**

The findings in the study described a complex set of student learning experiences about caring in the context of relationships with patients. Among the students, caring had no
single meaning, but rather was described as a multidimensional concept, experienced uniquely and contextually. Students’ understandings of caring were fluid, influenced by experience, and could be characterized as expanding and increasing in complexity.

Students described their earliest clinical experiences in critical incident papers written at the beginning of their program, and elaborated on them later in interviews. In revisiting early experiences, and in sharing subsequent experiences, students’ recognized they had developed new perspectives on the significance of caring relationships. These perspectives spoke to broader and deeper understandings of the meaning and complexity of caring relationship experiences.

These undergraduate nursing students experienced caring relationships in three interrelated stages that corresponded to a continuum of learning about caring. Different aspects of caring became important to students in each stage in connection with the extent and range of their relationship experiences. In this study, the stages were identified as learning about oneself, learning about others, and learning to be a care provider. Key findings within the stages encompassed experiences student deemed important to their learning in caring relationships.

In the first stage of learning about caring, students were aware of their efforts to express caring in their interactions with patients. They spoke of wanting to be accepted by patients as beginning care providers, and of connecting with patients as individuals. They realized they did not have much knowledge of nursing, yet learning that making connections with patients gave them a sense that caring could be a meaningful part of their role.
Stage II was characterized as learning about others. In this stage, students suggested that they developed interpersonal communication skills and formed relationships with patients. They spoke about reciprocal relationships as caring relationships. These relationships were perceived as reciprocal because students and patients respected and valued each other as individuals, and both participated in making care decisions in keeping with patients’ wants and needs. Students in stage II also valued collegial relationships with nursing staff. Students appreciated being respected by and learning from nursing staff, and communicated struggles with self-confidence when they did not perceive that staff saw their student nurse role as a legitimate one.

Student learning in stage III reflected growing competence in negotiating caring relationships and in responding to patients’ needs. In this stage, as students were approaching the end of their program, they described themselves as being more confident than in earlier stages, and wanted to provide care that was comprehensive. They shared how they came to appreciate the importance of interpersonal communication in opening up opportunities to create meaningful relationships that supported advocacy. They described acts of patient advocacy as examples of caring.

In stage III an ongoing challenge for students was to learn to manage the emotions they experienced in connection with close relationships with patients, who often faced serious illness. Students learned that demonstrating caring in relationships could be contingent on being able to suspend one’s own emotional response in favor of understanding and responding to what patients and their families needed. Also, although they had been observing role
models throughout their clinical learning, in this stage, they were more aware of how they sometimes needed a skillful nurse who could model caring behavior.

Students experienced caring relationships as dynamic processes involving learning and caring. As they gained experience in relationships, students moved beyond seeing caring solely as an affective state. Through greater involvement with patients, and deeper caring relationships, they broadened their views to include many dimensions of caring. The more they learned about themselves, about their patients, and about nursing and its associated activities, the more they perceived themselves to have a greater range of expressions of caring, affectively and behaviorally. Through experiences in relationships students emerged more confident about their preparation to be competent and caring providers.

**Conclusions**

The conclusions in the study follow from the research question and suggest there are a number of dimensions to how students experienced caring relationships. The three key conclusions that arose from the findings and reflected these dimensions of student experience are: (1) Caring relationships, as suggested by students, may influence their perceptions of the meaning and importance of their student nurse role; (2) Caring relationships may develop as stages on a continuum of learning about caring; (3) Student experiences in caring relationships may influence their perceptions of themselves as professionals.

**Perceptions of Role**

Students’ stories suggested that students came to perceive their role as beginning providers in caring relationships as meaningful and important to them and to their patients. In
general, research exploring nurses’ perceptions of their role describes the importance of
caring in relation to how nurses, and nursing students, find meaning in what they do. Studies
examine the influence of caring on making their role meaningful essentially from three
perspectives: caring as an internal experience of the nurse, caring interactions with patients,
and nursing interventions that represent caring acts. While students in the current study
experienced caring differently at different points in their curriculum, their thoughts about the
nature of caring, and their stories describing caring behaviors, reiterated, at some point, the
same emotive, process, and outcome attributes of being in a caring relationship that were
documented by earlier researchers, either among nurses or among nursing students
(Andershed & Olssen, 2009; Beck, 1993a; McCance et al., 1997; Morse et al., 1990;
Ranheime et al., 2010; Singleton, 2009).

Establishing a role. As they began their clinical experience, students looked for ways
to find order and meaning in the activities associated with their new and uncertain role. Too
inexperienced to fully act like nurses, students still wanted to make a difference for their
patients. When patients showed appreciation for students’ words or actions, students
suggested that they were better able to envision themselves in caring roles. This perception
helped them see their potential for caring and for contributing to patient care.

These findings are similar to those in two studies by Beck (1993a; 1993b), who found
that although students experienced a sense of anxiety and uncertainty early in their clinical
learning because they felt inadequate to the tasks before them, students also felt inspired by
having helped someone. They “left their first clinical day fortified with knowing their caring
made a difference to their patients” (Beck, 1993b, p. 494). Also in one of Beck’s studies (1993a), as well as in this study, expressing attributes of caring—presence, competence, emotional support, and physical comforting—provided nursing students with a sense of meaning and purpose in their role. And, involvement with patients in relation to these aspects of caring had other positive consequences for students such as increased confidence and self-esteem in terms of their image as nurses, and a realization of how caring can benefit the patient.

While the work of Watson (2008) was seminal in providing background for the meaningfulness of a caring role, other researchers who built on her work, framed more pragmatic contexts for understanding meaningfulness (Ranheim, Karner, & Bertero, 2010; Swanson, 1991, 1993). Studies reiterating key elements of caring described behaviors and attitudes found to be meaningfully linked to a caring role, such as empathy, concern for others, getting to know patients, and having an intention to care (McCance et al., 1997; Singleton, 2009). These elements also emerged as central in student experiences in this study.

**Meaning in nurse-patient relationships.** Other research on the meaning to nurses of their relationships with patients relates to findings in the current study. Among nurses in a study by Vouzaveli et al. (2011), and among students in the current study, caring and empathy were linked to meaningful relationships and to perceived importance of nursing work and nursing role. A personal connection between the patient and nurse was noted as essential to caring. This connection involved seeing the patient as an individual, and patients
and nurses mutually acknowledging each other as unique and valued persons (Halldorsdottir, 2008).

Corroboration of findings of a relationship between meaningfulness and a caring role was also noted in a study about how students understood suffering (Gunby, 1996). In this study, students perceived meaning and importance in their caring role when they listened, maintained human dignity, and connected with patients. This researcher noted that students found meaning when they had a commitment to care, and involvement with a patient’s situation that let them enter and be a part of the patient’s world. In the Gunby study, as in the current study, students believed communication created opportunities for deeper involvement with patients.

The findings in the current study largely confirm the work of other researchers detailed in an integrative review of the literature on nursing student relationships with patients (Suikkala & Leino-Kilpi, 2001). Findings in the current study specifically support what researchers in the review learned in regard to how caring relationships shaped students’ perceptions of the meaning and importance of their role. These included: 1) students perceived caring could be expressed fully in reciprocal relationships in which they and the patients benefited; 2) caring in close relationships was characterized by seeing patients as individuals; 3) finding ways to communicate caring helped students overcome anxiety when caring for dying patients.

In an essay in which Watson’s beliefs about the interdependence between nurse and patient in caring relationships resonate, Askinazi (2004) wrote about her experiences as a
nursing student discovering the meaning of caring. Her personal meaning making echoes the experiences of several students in the present study.

Askinazi described how the nurse-patient relationship created the potential for caring: “It’s an opening to feel a certain way; the mystery is how to reliably access that potential and the curse is what happens to us when we disregard it” (p. 33). She went on to talk about how in providing care for a patient who desperately needed her help, “All of a sudden . . . [her] work seemed to have more meaning. . . . [Her patient] was a person in misery and he . . . needed [her] hands and [her] presence” (p. 33). Askinazi went on to say . . .

I had somehow thought that the relationship between nurse and patient was a straightforward one-way connection between care-giver and cared for, the knower and the uninformed . . . But now the benefits were reversed. I was rewarded. I was restored. I was comforted—perhaps as much as the patient.

Askinazi shared her philosophical perspective on how she came to envision the nurse-patient relationship, elaborating on why caring is not “only good for the patient; it’s good for the nurse as well” (p. 33).

The secret of the nurse-patient relationship is the transforming potential of caring. When we care as nurses, we escape our own boundaries and egos as we completely and openly focus on our patients. At the same time, our patients’ personal boundaries are fraying, often because they have such a great need for physical or
emotional relief. Surprisingly, this permeability ends up making each patient and nurse able to form a new connection in that space that usually separates two people. (p. 33)

Brown, et al. (2001) point out that meaningfulness of work is a psychosocial construct influenced by whether the work one does is perceived to be important and useful to others. They also state that the internal experience of meaningfulness is associated with how well one identifies with the work. Fagermoen (1997) adds that meaningfulness in nursing is associated with the nurse’s personal values, which influence identification with the values of the profession and engagement in nursing activities.

How experiences in caring relationships may have influenced students’ perceptions of what was meaningful and important about their role was likely related to a number of factors. Their extensive contacts with professionals and exposure to patients in a wide variety of different clinical contexts likely had a shaping influence. Attitudes of nursing staff and clinical faculty may also be assumed to have influenced student perceptions. Among this constellation of influences, underlying personal values cannot be overlooked. And, in this sense, through relationships, students may have been able to actualize their values and recognize and communicate their personal meanings about who they were and what they did.

Thus, this study suggested that student nurses identified meaning and importance in their role through caring relationships. This conclusion corroborates the work of earlier researchers who studied the nurse-patient relationship (Halldorsdottir, 2008; Vouzavali et al., 2011), and those that looked at nursing student-patient relationships (Askinazi, 2004; Beck,
Also, since personal values influence engagement in nursing activities (Fagermoen, 1997), the study also suggest that students may have been influenced by their values to act for patients in ways that allowed them to express caring as novice nurses.

**Stages on a Continuum of Learning about Caring**

Students’ involvement with patients and with the circumstances of their illnesses were reflected in their range of caring processes in their relationships. Student descriptions of relationships in early critical incident papers and later interviews suggested that the depth of their involvement with patients was associated with the extent and variety of their learning experiences. Students’ descriptions also suggested that their experiences in relationships could be represented by the construct of a continuum of learning about caring relationships in stages. The stages seemed to encompass iterative learning experiences reflecting growth in students’ ability to engage in increasingly involved caring nursing behaviors. The stages were identified as learning about oneself, learning about others, and learning to be a care provider. In stages, students learned about caring and about being in a nursing student-patient relationship.

Researchers have discussed the progressive nature of clinical learning. Benner et al. (2009), Dyrbye et al. (2007) and Noone (2009), for example, looked at professional education from an apprenticeship perspective, noting how students acquired the knowledge and skills of their profession through guided contextualized experiential learning. No studies were found that related experiencing caring relationships to a staged process. In two studies, however, student progress in clinical was discussed in terms of stages. These studies
addressed how students become morally aware (Lemonidou, Paphanassoglou, Giannakopoulou, Patiraki, & Papadatou, 2004) and how they learned to address patients’ spiritual needs (Giske & Cone, 2012).

Lemonidou et al. (2004) uncovered a continuum of stages of increasing moral awareness among nursing students. The continuum began with empathy and compassion, was followed by identification with the nursing role, and led to taking a moral stand on behalf of patients. As part of their development, students experienced moral conflict in challenging situations, learned to transcend the conventional ethics of the unit when they did not agree with them, and acted in ways that served patients and provided the students with moral satisfaction with their actions. Giske and Cone (2012) described stages in how nursing students learned to provide spiritual care to patients. These stages were preparing for connection, connecting with and supporting patients, and reflecting on experiences.

The findings in the present study, while substantively different from the findings in the studies by Lemonidou et al. (2003) and Giske and Cone (2012), are nevertheless related. The current study, and these two studies, demonstrate how deconstructing complex processes, such as becoming a caring professional, becoming a moral agent or learning to provide spiritual support to patients, illustrates essential components that make up the processes and the relationships among them. Examining basic elements of complex learning in this way delineates how students come to understand dimensions of their professional role. By looking at experience in stages, we can also gain insight into how students explore personal values and the meaning of their values to themselves and to their practice. As
Lemonidou et al., (2003) pointed out, students in their study were “realizing and refining a set of personal values, referenced to real situations, [and] validated by emotions” (p. 127).

When compared to becoming a moral agent and developing personal spiritual resources, however, experiencing caring relationships is somewhat different. Being in caring relationships suggests exposure to a broader spectrum of related learning about self and about nursing than either becoming a moral agent or developing approaches to spiritual support, and, in fact, subsumes these latter two learning processes. Unlike the findings in the studies by Lemonidou et al. and Giske and Cone, the findings in the current study suggest broader stages of learning, articulated in general terms, are needed to describe how students experience caring relationships.

The stages in the current study were characterized by patterns of student learning, with new learning throughout the nursing program illuminating new aspects of how students experienced caring relationships. This new learning was influenced by, reiterated, and added to earlier learning. The stages were therefore represented as being interrelated. The learning patterns described in each stage were associated with clinical learning in relationships.

**Stage I - Learning about Oneself**

In stage I, the focus of student learning was on finding a caring purpose while interacting with patients. Two sub-themes described students’ experiences in this stage—being accepted by the patient and forming connections with patients. Students did not yet have the experience, or belief in themselves as caregivers, to establish relationships easily with patients. They viewed their provider status as tenuous and wondered how patients would
respond to them. Still, they explored what it was like to get to know patients and form connections with them. They began to find significance as caring providers in seeing patients as individuals with whom they felt they made human-to-human connections.

Hagerty, Lynch-Sauer, Patusky, and Bouwsema (1993) explained connectedness in a way that relates to these student experiences. They described connectedness as being actively involved with another person in a way that promotes a sense of comfort, wellbeing, and anxiety reduction. It usually implied an emotional connection, was preliminary to forming a relationship, and was necessary to a sense of belonging. Interpersonal processes in the two sub-themes in the first stage of learning in the current study--being accepted by patients and making caring connections with them—in particular, reflected the sense of connectedness Hagerty et al. (1993) described.

Students talked about caring in stage I as an emotion and a motivation to help. They spoke of gaining insight into patients’ feelings and needs and recognized that empathy was a part of caring. Stories suggested efforts to connect with patients represented the beginnings of therapeutic student nurse-patient relationships.

In stage I, they were in the novice stage and did not appear to understand caring as a core nursing value. Core nursing values are professional values that form the foundation of relationships with patients, and are demonstrated to help patients achieve optimal health and wellness outcomes (Vezeau, 2006). This finding was consistent with how Wilkes and Wallis (1998) classified early caring experiences for students as caring in a generic sense, then differentiated this kind of caring from professional nurse caring, which does not occur until
later in the student’s program. In this study, although learning in caring relationships early in
the program was more personal than professional, it was likely an important step in
supporting students’ transitions to becoming professionals.

**Being accepted.** As part of a caring relationship in the early stages of learning,
students were uncertain about their role. Most suggested that they had nothing to offer ill
patients and might be a bother to them. They felt they might burden patients by asking to
engage with them when they believed the purpose of their interactions were to meet the
students’ learning needs, not to help the patient. They worried about whether patients would
welcome them since they were not yet real nurses.

Feeling unsure about one’s role and feeling like one is placing an additional demand
on an ill patient was not a finding unique to this study. In medical students’ early encounters
with patients, students felt uncomfortable interacting with patients, believing they were
practicing skills but not helping patients with their illness concerns. They believed they “took
away valuable time from patients and their families, made patients needlessly tired, were an
imposition, and inflicted unnecessary pain without the patient gaining anything in return”
(Drybe et al., 2007, p. 981). However, medical students, as well as the students in the current
study, came to realize that patients appreciated the time and effort students put into their
interactions with them, and perceived their efforts to be helpful additions to their care.

In this study, students suggested that they hesitated to enter into interactions with
patients because they were anxious. Other researchers also described student anxiety about
new clinical learning, especially in initial contacts with patients, noting that anxiety can be a
barrier to clinical learning (Beck, 1993; Chesser-Smyth, 2005; Melincavage, 2011; Moscaritolo, 2009). In these studies, feeling inadequate, fear of making a mistake, and fear of failure were predominant themes related to anxiety, suggesting, perhaps, students in the current study had similar fears. As in the study by Drybe et al. (2007) and in the current study, Chesser-Smyth (2005) noted, “participants’ descriptions of a receptive welcome [from patients] were highly valued” (p. 323), and had a positive impact on students’ self-esteem.

**Forming connections.** Connection with others has been found by researchers to signify a caring relationship (Halldorsdottir & Hamrin, 1997). For the students in this study, forming connections with patients also signaled caring experiences. Common descriptions from students regarding the nature of connections revolved around getting to know each patient as a unique person. Similarly, in a study by Fredriksson (1999), students found listening to be a way to enter the patient’s world and a first step in connecting with them.

Students described making connections in different ways: recognizing an aphasic patient’s need to have someone listen while she struggled to express her concerns; having a patient voice appreciation for the lotion a student rubbed on her hands; listening to a cystic fibrosis mother of a teen-ager talk about her concerns over whether she would live long enough to raise her daughter. Forming connections were important representations of caring. Through connections students gained confidence and allayed their self-doubts about competence. Connections made students aware that caring was an important aspect of the student nurse-patient relationship.
The importance to student learning of person-to-person connections found in this study corroborates findings in earlier studies by Beck (1993a) and Suikkala and Leino-Kilpi (2001). Beck (1993a) found authentic presence a fundamental condition for connections. She pointed out authentic presence encompassed listening to patients express fears and anxiety and responding sensitively to their needs. Suikkala and Leino-Kilpi (2001) noted that seeing patients as individuals and having face-to-face encounters with patients were essential in forming connections. They also reiterated that students needed to become aware of their own feelings in order to learn to initiate a caring relationship, and that personal growth and increased confidence and self-esteem were student reported consequences of the processes they went through to form connections.

**Stage II – Learning about Others**

The second stage in learning about caring relationships was identified as learning about others. Although I did not conduct a longitudinal study of student nurses, students shared stories of early clinical experiences and experiences they had later in their program. These stories suggested a second stage of learning in which students looked beyond themselves and began to see patients as people with individual lives, and, secondarily, as people who also had medical and nursing needs. These novice nurses described interactions with patients that suggested they had made gains in acquiring nursing knowledge and developing interpersonal communication skill through earlier clinical exposure. They wanted to be respected by staff for the contributions they were now able to make to patient care. They no longer viewed caring solely as an emotion or as being embedded in the process of
forming connections with patients. Caring permeated many aspects of their patient relationships. The sub-themes in this stage representing learning about others were developing reciprocity and being respected.

**Reciprocal relationships.** Reciprocity has been defined as a condition of mutual dependence, action or influence (Merriam-Webster, n.d.). Hagerty et al. (1993) noted that reciprocity was the individual’s perception of equal and complementary interchange with another person that involved sincere giving and taking in a relationship. Experts have established that caring is a therapeutically reciprocal concept (Noddings, 1984; Watson, 1985). Lundgren and Berg (2010) explored the notion of reciprocity in nursing relationships by examining one aspect of reciprocity — the meaning of receiving care from the perspectives of patients, nurses and nursing students. They found not only patients wanted to be valued as receivers of care; nurses and nursing students thought being valued as providers by patients was also important and described reciprocal relationships as those in which both parties participated in care decisions.

Lundgren and Berg (2011) characterized reciprocal relationships for nurses and nursing students as interaction involving mutual empathy and understanding between those receiving care and those giving care when both feel that they are of value. For patients, this meant they felt supported when the nurse showed compassion and empathy, and acknowledged them as individuals whose “worries are accepted and recognized” (p. 238).

In the current study, when students felt valued by patients, they often described their relationships as ones in which they were “caring.” They felt like they could communicate
openly and honestly in these relationships, be themselves, and see and accept patients for who they were. They were therefore more comfortable in carrying out nursing activities, and patients affirmed for students that they saw them as capable caring providers. Having a reciprocal relationship with a patient opened up avenues for communication in which students could improve listening skills, and patients could become participants in their care by sharing important information and personal concerns with them.

Marck’s (1990) definition of a reciprocal relationship relates to the current study and offers elaboration on current findings. According to Marck, in a reciprocal nurse-patient relationship, mutual learning takes place. Each participant holds some responsibility for building trust through “mutual exchange of meaningful personal perspectives... The client gains efficacy in coping with the concerns underlying help seeking, and the nurse experiences efficacy in the provision of care that genuinely helps” (Marck, 1990, p. 52). In a reciprocal relationship, both participants contributed to the shared meanings that can be created through the interactions of both parties.

The importance of reciprocal relationships in communicating to patients that they are valued was reiterated in the Institute of Medicine report on the need for health care organizations to adopt patient-centered care (Institute of Medicine, 2010). Lusk and Fater (2013) analyzed the concept of patient-centered care and determined measurable variables linking nursing care to patient-centered care. Their findings of essential nurse behaviors that defined patient-centered care included those found in reciprocal relationships—listening, communicating, and valuing the patient’s individuality. Lungren and Berg (2010) reiterated
the importance of reciprocity by concluding that reciprocal relationships preserved patient and nurse dignity.

Findings in this study indicated that although students found most relationships to be reciprocal, and exhibited the characteristics of reciprocity made explicit by earlier researchers, sometimes it was difficult for them to make connections and be in relationships they perceived as reciprocal. One type of situation that was difficult for students in this study was caring for seriously ill or dying patients. Other studies also noted that providing care for very ill patients caused students anxiety and feelings of inadequacy (Cook, 1996; Suikkala & Leino-Kilpi, 2001). In the studies by Cook (1996) and Suikkala and Leino-Kilpi (2001), students’ concerns included fear of making a situation worse by not knowing what to say and saying the “wrong” thing, or harming a patient because of a lack of skills. In the latter two studies, and in this study, students stated that facing emotional challenges of caring for seriously ill patients promoted their professional growth. They learned they could provide effective care to these patients that included caring interactions.

**Being respected.** Students’ interactions with nursing staff comprised another theme in the second stage of learning about caring. Students shared stories of problematic situations in which they received no guidance from nursing staff. Not feeling heard, and feeling unable to act, left students feeling uncertain in their role and insecure about their capability as novice nurses. When nurses welcomed students into collegial relationships, students felt respected.

These findings are similar to what other researchers have found. Students viewed involvement with nursing staff as critical to their learning. Relationships were helpful when
staff shared their knowledge and decision-making processes, when staff took an interest in teaching, and when staff made students feel welcomed (Attack, Comacu, Kenny, LaBelle, & Miller, 2000; Matsumura, Callister, Palmer, Cox, & Larsen, 2004).

Additionally, when nurses were disrespectful, students felt marginalized in their community of practice. Using situated cognition learning theory, Melincavage (2011) explained that legitimate peripheral participation in a community of practice allows learners to “gradually absorb and be absorbed by the culture, and provides opportunities for learners to make the culture their own” (p. 788). Legitimate peripheral participation can be empowering when students move centrally, but if denied the opportunity to move centrally, they can become powerless.

Further, in some studies, nursing students’ motivation and capacity to learn, their self-concept, and their confidence were affected by a lack of a sense of belonging when they did not feel respected by nursing staff (Levitt-Jones, Lathlean, Higgins and McMillan, 2009). Students pointed out their need for collegial relationships with staff. They felt valued and respected when sharing knowledge of patients was a two-way process between the staff nurse and the student.

**Stage III – Learning to be a Care Provider**

As students approached the end of their program, they were able to provide more comprehensive care. In addition, caring for patients had taken on greater dimensions associated with their advances in learning. Student stories described interactions with patients in which student competence and confidence predominated as attributes of caring. This
competence and confidence were expressed in stories as ways students used knowledge and skills to meet complex patient needs as well as in their caring attitudes. At this stage of learning, students suggested that they had advanced in their ability to provide many aspects of care, but noted, in particular, the importance of communication in these relationships and of acting as patient advocates. The sub-themes that emerged characterizing this stage were becoming better communicators, becoming patient advocates, and acting as caring professionals. These sub-themes reflected students’ new abilities for deeper involvement with patients and greater use of nursing knowledge.

**Becoming better communicators.** In stage III, students recognized the importance of communication in improving the quality of their relationships with patients. They saw how interpersonal communication enabled them to build trust. They also perceived relationships as most caring when patients were comfortable enough with them to share significant information about themselves. Although students believed communication was a key factor in strengthening relationships, what they meant by “better communicator” was not entirely clear. Overall, their descriptions of being good communicators seemed to mean knowing more about patients, and being more deeply engaged with patients and with the contexts of their care situations. Some students equated listening with caring.

Interestingly, two studies that looked at communication in the nurse-patient relationships have contradictory findings. A common perspective in nursing education is teaching therapeutic communication. Rosenberg and Gallo-Silver (2011) explained that therapeutic communication is “a professional technique founded on empathy and boundary
maintenance for the purposes of increasing understanding and stress reduction in both the cared-for and the caregiver” (p. 3).

Hartrick (1997), however, presented a different view. She believed forms of communication usually taught to nursing students as therapeutic are, in fact, restrictive and can impede relationships. To Hartrick, the prescribed ways of communicating that are usually taught in the classroom setting as therapeutic are not intrinsically therapeutic and can instead foster mechanistic ways of relating to patients. As an alternative, she proposes a model of human relations that reflects humanistic values; that is, communication that does not follow the rules of therapeutic communication—rules such as using open-ended questions, asking for clarification, and avoiding confrontation. In Hartrick’s model, nurses do not struggle to find the right thing to say. They avoid scripts and are motivated by genuine concern to know and understand the patient’s beliefs and values. Fredriksson (1999) added that in a relational model of communication, humanistic relating is marked by inter-subjectivity and is associated with being with patients as they deal with their illness experiences.

Halldorsdottir (2008) presented a view similar to that of Hartrick and Fredriksson which also describes the nature of the experiences of students in the current study. She noted that patients perceived nurses to be caring when nurses got to know them as persons, and communicated with them in a way that made them feel they were accepted as individuals rather than as patients. Presence, or being with patients communicated to them they were of value and worth the student’s time.
**Becoming patient advocates.** Students in the latter semesters of their program suggested they were in a third stage of learning about caring relationships. They described themselves as able to actualize caring through their role as patient advocates. In this capacity, their caring was directed at improving the health and wellbeing of their patients. Being a patient advocate meant a student had insight into individual expressions of illness needs, and an understanding of what about the illness was important to the patient. Students were able to keep the patient’s needs foremost in how they planned care.

Literature on patient advocacy abounded. Wilkes and Wallis (1998) described advocacy as professional nurse caring, noting that students in their final year of their program, while still motivated by compassion, included doing nursing actions as a chief component of caring. In the current study, toward the end of their program, students also described a greater range of nursing actions. One student noted how her support helped an unsure teen-ager participate in an important meeting in which her living arrangements after discharge were to be decided. Another student described knowing how to help a patient who became physiologically unstable.

Other researchers who looked at advocacy among nurses studied advocacy from a conceptual perspective and from the perspective of understanding the lived experience of acting as an advocate (Bu & Jezewski, 2006; Hanks, 2010; MacDonald, 2006; Vaartio-Rajalin & Leino-Kilpi, 2011). Curtin (1979), in proposing a theory of advocacy, pointed out that caring nurses get to know patients and attend to them as distinct and unique human beings. Bu and Jezewski (2006) found three core attributes of the concept to be safeguarding
patients’ autonomy, acting on behalf of patients, and championing social justice in the provision of health care.

Among researchers who reviewed the concept, Vaartio-Rajalin and Leino-Kilpi (2011) identified three categories of advocacy, each describing patient advocacy activities performed by cancer nurses. These categories were analyzing patients’ needs, informing patients so they felt they were able to make educated decision, and responding to patients’ care preferences.

Hanks (2010) and MacDonald (2006) noted that an emotional connection with, and full engagement in, patient experiences were essential elements of advocacy. Further, nurses’ values and beliefs underpinned advocacy actions. Advocacy was seen to strengthen an already caring nurse-patient relationship. These researchers also pointed out how good communication and patient advocacy were linked. Relationships involved strong connections in which nurses knew patients’ particular needs and wants. Advocacy experiences also reflected moral agency “embedded in the subjective experience of the interpersonal relationship between nurses and patients” (MacDonald, 2006, p. 123).

Some of the advocacy behaviors noted by previous researchers were also noted in the present study, including knowing patients’ wants and needs through active listening and relationship building, and the development of an emotional connection with patients. Moral agency was not directly described but was suggested in student behavior. [Students did not share any stories regarding social justice advocacy.] Additional behaviors identified by others
Acting as a caring professional. While students in this study attained knowledge, confidence, and competence in interpersonal relationships by the end of their program, they also learned they could still experience unexpected and sometimes intense emotions while providing patient care, especially in difficult situations. Experiencing these emotions was important to their professional growth as a caring professional, but students often felt constraints in knowing how to express them. One student said she wished she had someone to talk to about what she experienced.

Handling emotions. Suikkala and Leino-Kilpi (2001) noted that caring for challenging patients in emotionally difficult situations could be extremely difficult for students but could promote their personal growth. Huynh, Alderson and Thompson (2008) discussed emotional labor as an important concept underpinning caring. Emotional labor refers to the internal regulation of emotions. It is a process whereby nurses adopt a ‘work persona’ to express their emotions during patient encounters caring for ‘difficult’ patients. Nurses assume this persona when they believe their actual feelings are not consistent with the caring emotions they should experience professionally. Emotional labor refers to efforts to display “emotions according to embedded social and cultural norms rather than what he or she actually feels” (p. 196).

Students in this study seemed to be ingenuous about the concept of emotional labor. They did not want to pretend they felt differently than they did but seemed to be perplexed...
about how to process their emotions when they did perceive a need for internal regulation of
their feelings because of circumstances with patients.

Students in this study also commonly talked about having difficulty in knowing how
to stay emotionally connected with patients while still keeping an objective stance. These
kinds of feelings have been described in the work of Halldorsdottir (2008), who noted the
nurse-patient relationship contained two inter-related processes: the development of a caring
connection but also the maintenance of a comfortable emotional distance.

**Observing role models.** Charneia (2007) noted the importance of role models in
professional education, pointing out that students can acquire cognitive skills as well as new
patterns of behavior from role models. Role models can have a significant impact on student
learning in particular, when students are just beginning to learn their professional role. In the
current study, students gave examples of how they learned caring behavior by observing how
nurses interacted with patients.

Role models influence student behavior because role models are seen as competent,
as someone the learner sees as similar to himself, and as someone who has a caring attitude
toward patients (Wiseman, 1994). Role modeling is among the most powerful ways students
learn professional attitudes and behaviors in the clinical setting, including caring (Charneia,
2007). Cruess, Cruess, & Steinert (2008) note that we model ourselves consciously and
unconsciously on individuals we trust, respect, and aspire to be like.

By representing how students perceived their experiences in caring relationships with
the construct of stages on a continuum, the processes in these experiences can be
deconstructed into key elements. With descriptions of key elements, nurse educators can better understand what it is actually like for students to be in those relationships. Nurse educators can guide student learning in clinical more carefully when they have a clearer picture of how students perceive their learning about caring.

**Students’ Perceptions of a Professional Self**

The third conclusion in this study suggested that being in caring relationships may influence how students see themselves as professionals. Students’ professionalism was assumed from the way students described their caring attitudes and behaviors. For example, students noted the importance of caring in nursing; they described themselves as able to care in more “diverse” ways, as not hesitating to interact with patients, and as being “more confident in their caring” as they advanced in their program. Their stories illustrated that they perceived their relational connections to be important, reflecting their full engagement with patients and families. Students suggested they wanted to be with patients and enter and understand the complexities of each patient’s world. Deeper involvement allowed them to create more opportunities for caring. They accepted patients for who they were and expected that they would be able to provide care for them no matter what unfolded in each patient care context.

Vezeau (2006) points out that professional values are “standards for action that are generally accepted by the group as a whole, expected of its practicing members, and socialized into its novices” (p. 5). While students did not articulate any of their professional values, their caring behaviors suggested an internal standard for nursing behavior that could
reflect professional values. Study findings suggest that how students came to conceive of themselves as professionals was related to a process of socialization, influenced by learning in caring relationships.

**Values and socialization.** Values, which are derived from personal beliefs, determine what individuals choose to think and do regarding what is good, worthwhile, or desirable (Clark, 2009). Values develop gradually over time and once developed, guide decision-making and behavior. Personal values are derived from family, culture, society, environment, religion, and ethnicity. Professional values are developed through professional socialization and guide an individual’s behavior regarding what is desirable as a member of a profession (Clark, 2009). Values are inherent in developing and sustaining professional identity and are expressed in nurses’ actions in relation to others (Fagermoen, 1997). Nurses’ professional values affect the decisions they make regarding how they provide care for patients (Clark, 2009).

The American Association of Colleges of Nursing (AACN) described the values of the profession in the *Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008). The values included altruism, patient autonomy, respect for human dignity, personal integrity and social justice. The AACN pointed out that a caring nurse reflects these values in professional practice.

As the AACN suggests, interrelated sets of values can underlie caring behavior. Fagermoen (1997), in studying how values are embedded in meaningful nursing practice, found altruism, defined as the concern for the care for patients’ health and well-being, was an
overall philosophical orientation guiding nursing practice. Respecting human dignity was also found to be a core value. All other values were linked to human dignity “either by arising from it and/or being aimed at preserving this basic value” (p. 439). Similarly, in a study by Oberle and Davies (1993), ‘valuing,’ which meant having respect for the inherent worth of others, affected all the nurse’s activities.

Fagermoen (1997) has defined professional identity as “the values and beliefs held by the nurse that guide her/his thinking, actions and interaction with the patient” (p. 435). Practically speaking, professional identity gives the nurse a basic frame of reference for practice. It has a central influence on how problems are identified and what goals and approaches to patient care are pursued. Nursing students’ professional identities are linked to their value development and their socialization into the profession. Fundamental to the socialization process is the internalization of values of the professional culture into the student’s own behavior and self-concept. As values develop during the educational process, so, too, does the formation of identity (Weis & Schank, 2002). Weis and Schank (2002) note that an incomplete integration of values may explain why nurses progress differently in mastery of nursing practice.

While values are the cornerstone of professional identity formation, developing professional behaviors is an equally important factor in the socialization of students as they journey toward becoming nurses. To be a caring professional, for example, depends as much on students’ communication and interpersonal skills within relationships with patients, as on their feelings of empathy and compassion that are so closely connected to caring. Plack
(2006) notes that competence for physical therapists, and therefore, likely for nurses, depends not only on knowledge and skills, but also on values, attitudes and beliefs that allow providers to interact effectively with patients. Without these values to inform their behavior, students would not be able to have the meaningful interactions that enable them to know their patients.

Further, a professional identity is developed as the student takes a role as an active participant in providing the patient’s care. Plack (2006) cites the work of Dewey (1938) and Kolb (1984) as foundational in explaining the nature of experiential learning of students as they assimilate values and learn professional behaviors. Tennant and Pogson (1995) believe that this aspect of professional identity formation occurs tacitly through immersion among other experienced professionals, while Lave and Wenger (1991) emphasize the movement of the student from a marginal place to total engagement in the community of practice. They explain that contrary to the beliefs of some that tacit learning is “caught and not taught,” learning occurs through engagement in social practice and involves negotiating ways of being in the community and interacting with others in the community. It is through continually renegotiating the meaning of “one’s day-to-day lived experiences” that professional identity develops (Plack, 2006, p. 38).

In Plack’s study (2006), students not only made personal meaning of an experience but through dialogue with other professionals, developed shared meanings that reflected professional values and attitudes. Plack (2006) noted that becoming a professional was “more than simply applying knowledge amassed in school” (p. 44). It is likely that for the nursing
students in the current study, as for physical therapy students in Plack’s study, interactions with others in a community of practice meant identifying self as a nurse and as a member of the profession.

**Shifting perspectives.** Benner et al. (2010) reiterated the ideas of Lave and Wenger and Plack, and illustrated how formative experiences both reflect values and contribute to professional identity. These researchers related one student’s thoughts about how she had to shift perspectives in order to assume a professional role.

> You kind of get caught up in all the tasks and we all want to do tasks, but you also have to remember that there’s a person at the end of the bed and that’s just as important as putting in an IV. (p. 166)

In order to learn to focus both on the task and on the “person at the end of the bed” students must “form new habits of thought and action and relinquish old habits and perceptions” (p. 166). This process reflects socialization into the profession, acquisition of professional values, and the development of professional identity.

Further, it is an identification with the values of the profession that keeps students focused on their goal to complete the sometimes arduous work of their nursing programs, especially when they face difficult and challenging situations and experiences (Benner, et al., 2010). Interestingly, Worthington, Salamonson, Weaver, and Cleary (2010), in evaluating the predictive properties of a professional identity scale for undergraduate nursing students,
found the degree to which students assumed a professional identity had a direct relationship with their retention in their nursing program.

There are many similarities between the findings in the current research study and these studies in relation to caring, learning values and attitudes, assimilation into a community of practice, and professional identity formation. Benner et al. (2010) points out how stories that reflect changing perspectives on caring are formation stories that help students acknowledge how a particular learning experience “changed their perspective, their self-knowledge, their understanding, or had reassured them that they were on the right path and that they were going to be good at their chosen profession” (p. 167).

In this study, most of the stories were about what Benner et al. (2010) called identity-conferring experiences of caring. Primary formative caring experiences of students in this study included caring through knowing the patient as a person, through being with that person in a reciprocal relationship, which sometimes entailed witnessing patient suffering and providing comfort measures. Students felt caring when they recognized and preserved the patient’s dignity and worth; when they helped patients clarify their personal beliefs about end-of-life care; when supporting a family who did not understand their loved one’s condition and therefore his options for care. One student felt caring when speaking for a vulnerable patient who was at risk to have her care needs overlooked because she couldn’t speak for herself due to aphasia. Another believed she was caring when she persuaded a reluctant patient to speak up and let his physician know his concerns.
To form connections and build relationships, students learned to interact with patients in certain ways that included attentive listening, being ‘present,’ accepting and exploring the patient’s feeling, even when they were negative feelings. They had to learn to create a relationship of mutuality and respect in which they encouraged the patient’s participation in care and tried to understand the patient’s perspective (Rider & Keefer, 2006). Essentially, they had to reform how they related to others, in effect, learning “to change the boundaries of their social access” (Benner et al., 2010, p. 182). Relating to patients in new professional and caring ways required students to develop interpersonal communication skill. How they used their skills reflected their underlying values.

Students in this study spoke of the challenges they faced in relationships becoming close to patients in caring, meaningful ways, yet remaining objective and professional in order to provide good care. They had to learn skills of involvement in order to stay emotionally connected with patients and families, but also had to learn to filter and modulate their emotional responses. These were essential steps for them in becoming a professional. Benner et al. (2010) found that nurses, who did not learn to become involved with the problems or situations of their patients, or engage in interpersonal relationships with patients, families, and team members, did not become expert nurse even with considerable experience.

**Affective learning.** How students assimilate values and express them in their communication and interpersonal skills is difficult to identify and make explicit (Halldorsdottir, 2008; Noone, 2009). Educators have used the term “affective” to describe the kind of learning that involves attitudes, beliefs, and values. But discussions of affective
learning are uncommon because learning that involves attitudes or values is not easily measured and is usually inferred from the behavior that follows from the subjective state of the learner (Maier-Lorentz, 1999).

Professional identity is learned primarily through the affective domain. Noting the paucity of research in this area, Weis and Schank (2002), recommended that educators strengthen existing nursing education programs “(1) by exhibiting their commitment to professional values through role-modeling behaviors related to these values; and (2) by systematically providing other value development experiences both in classroom and clinical settings that serve to socialize nursing students to the profession” (p. 273).

The current study focused on describing how nursing students experienced caring relationships. Integrating personal and professional values and becoming a professional were associated with their experiences. Much of what was involved in how students learned to become a professional was hidden or was implicit in curricula. This study noted that students needed explicit opportunities for affective as well as cognitive and psychomotor learning to engage in caring relationships.

**Implications**

The findings in this study contributed to a clearer understanding of how students experienced caring relationships with patients. Caring was found to be a complex and multi-dimensional concept, reflected in student attitudes and behavior, which appeared to have potentially changed over time with additional learning. Expanded concepts of caring relationships were associated with advances in interpersonal communication skills. Having
these skills gave students the confidence to engage with patients and to learn about how they could address their concerns.

Experiences in caring relationships appeared to influence how students perceived meaning in their role as care providers. Students’ stories suggested that their experiences reflected a process of learning about caring relationships in stages. They also suggested that experiences in caring relationships were associated with learning the values of the profession, and with the process of realizing a professional sense of self. The conclusions from the study have implications for theory, practice and research.

**Implications for Theory**

Parallel ideas are apparent between findings in this study and concepts in Jean Watson’s theory of human caring (2008). In a broad sense, findings lend support to Watson’s theory. The theory of Watson and the findings in this study emphasize that caring gives meaning to the role of the nurse. The heart of the theory, and of this study, rest on the notion that caring is an important component in the inter-subjective experiences of patient and nurse.

While there is correspondence with general aspects of Watson’s theory, findings in support of specific elements in the theory are inconclusive. Because the study did not set out to make explicit students’ inner experiences regarding the notions of presence, transpersonal relationships, and caring encounters, links between findings and these concepts remain elusive and unarticulated. Similarly, findings suggest associations between students’ caring behaviors and the *caritas* processes, but connections between these guides to caring and
student behaviors were not specifically explored. Still, the usefulness of the theory can be seen in the way it centers the study of student experiences in caring relationships within a theoretical framework.

Watson suggests that for patients and nurses to experience inter-subjectivity in their relationships, both parties have to be open to knowing each other, learning from each other, and sharing a bond that has philosophical and/or spiritual overtones. Although nursing students developed caring relationships, the personal dimensions of their experiences, when compared to what Watson posits, were not apparent in their stories or statements.

Students’ stories about their early clinical experiences described a primary focus on learning about themselves. Students sometimes experienced role uncertainty and anxiety regarding new learning and new encounters with patients. One can speculate that early in their clinical learning, it is likely that most students were not ready for the kind of orientation to another person and to a relationship that Watson presupposes as essential to caring. While some of Watson’s concepts may have informed caring relationships of some students in this study, at some point in their clinical experience, and to some degree, it does not appear that overall, their experiences in caring relationships could be explained by the theory.

Because support for elements in Watson’s theory was largely unexplored, future research might illuminate whether students’ perceptions of caring experiences align with the key elements as Watson describes them. Specifically, future research could better elucidate relationships between caritas processes and student experiences, and explore student perceptions of the nature of transpersonal interactions, inter-subjectivity, and caring
encounters. Findings suggest students may not have reached a point in their learning and experience where they could fully demonstrate all dimensions of how Watson describes caring relationships. Future research could explore ways to consider how Watson’s theory might be extended to include a more comprehensive picture of students’ clinical learning in caring relationships.

**Implications for Practice**

Findings from this study suggested that it is important for educators to be aware of key aspects of how students experience caring relationships. Clearer understandings of students’ perspectives on what their experiences with patients are like can help educators potentially identify and address anticipated problem areas of student learning. Understanding the student perspective can also help educators selectively find ways to facilitate or enhance what students and nursing curricula perceive as being most important about their learning. Also, the focus of many educators has been on the formal knowledge of the discipline, and on helping students develop competence in psychomotor skills. Findings in the study emphasize that understanding how students acquire a set of beliefs about the meaning of caring relationships, and become someone who embodies the values of the profession are equally important aspects of clinical learning. Students need to receive a balance of learning opportunities from cognitive, psychomotor and affective domains.

Nurse educators can help student learning in the following ways:
Recognize the impact of students’ emotions on clinical learning. Students may not share their feelings and may feel isolated when they cannot express them. Nurse educators can help normalize feelings for students.

Recognize when student anxiety specifically occurs, and how it negatively affects learning, especially in early clinical experiences. Nurse educators can devise strategies to prepare students in advance to experience less anxiety in clinical, as well as strategies to help students manage their anxiety.

Recognize that just being in the clinical setting and interacting with patients does not guarantee that students will develop interpersonal communication skills (Plack, 2006). Nurse educators can assist students in developing the advanced communication skills they need to interact with patients who are often seriously ill and require complex care.

Create psychologically safe learning environments by collaborating with nurse managers to ensure that staff nurses understand students’ level of preparation and are prepared to provide support for role development.

Guide students who are not in reciprocal relationships to recognize how complex circumstances surrounding patients’ response to illness can affect patients’ abilities to engage in relationships with them.

Be knowledgeable about the fundamental values of the profession in order to help students reflect on their experiences in expressing these values.
Recognize the importance of affective learning in relation to values and interpersonal communication.

Develop affective learning objectives and outcomes to make affective learning explicit in curricula.

Develop teaching strategies that integrate affective learning.

**Implications for Research**

Students spent considerable time and energy understanding the scope, importance, and meaningfulness of their caring role to themselves and to others. They came to realize that through it, they could influence patients’ wellbeing. However, findings focused on students’ perceptions of caring relationships did not explore the dynamics of how students’ created relationships or their caring roles within them, nor what, specifically, patients experienced as caring from students. Future research could explore these topics more fully, providing additional insights into the nature of caring relationships.

A major contribution of this study to the current body of research on caring relationships was in providing insights into how students experienced learning about caring in stages. Future research can extend these findings through replication, perhaps with different student populations or larger numbers of students, and also explore aspects of the sub-themes identified in each of the stages more thoroughly.

Strong communication skills are critical in caring relationships. An unexplored topic is the role of interpersonal communication, which is key in developing and maintaining relationships. There is also minimal research on how students’ learn and use their
interpersonal communication skills. Research could also focus on communications styles. Suikkala, Leino-Kilpi, and Katajisto (2008) noted that students used different communication patterns. Patterns described as facilitative fostered an attitude of reciprocity and more engagement with patients.

Future research is needed on how students are socialized with the values of the profession, and how caring is but one aspect of these values. Research is also needed on how affective learning strategies can be used to help students recognize their own values and those of the profession.

Lastly, healthcare today emphasizes evaluating outcomes of care. There is considerable interest in linking nurse caring to improvements in patients’ satisfaction with care, and to their health and wellbeing. Additional research is needed to describe how student nurses are perceived by patients to contribute to these outcomes.

**Summary**

This study used a narrative case study approach to explore and describe the nature of student experiences in caring relationships with patients. The research question guiding the study was: How do nursing students experience caring relationships with patients? Fifteen junior and senior students enrolled in a baccalaureate program in nursing provided the data for the study through stories they shared in critical incident papers and interviews.

In analyzing the stories, patterns emerged describing how students learned about caring relationships. These patterns were represented by three interrelated and iterative stages of learning about caring, identified as learning about oneself, learning about others, and
learning to be a care provider. The stages, which were depicted as a continuum of learning about caring, encompassed experiences reflecting students’ ability to provide increasingly multifaceted nursing care and engage meaningfully with patients as they advanced in their program.

Additional themes were associated with learning about caring. These were seeing patients as individuals, and finding affirmation of one’s role through reciprocal relationships. Other themes included the importance of having collegial relationships with staff nurses, learning to deal successfully with difficult emotions in a professional manner, serving as a patient advocate, and observing caring behaviors in other nurses. Caring was represented by students as internal, as embedded in interpersonal communications, and in nursing actions.

Conclusions in the study suggested that students’ experience stages of learning about caring relationships; their perceptions of meaningfulness and importance in their role may be associated with their experiences in caring relationships; and experiences in caring relationships may influence students’ perceptions of themselves as professionals.
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APPENDICES
Appendix A
Interview Guide

Critical Incident Questions

1. Think back to the critical incident you described in your paper. What do you remember or recall?
2. If there was one main memory of this incident, it would be . . . . . ?
3. After reading your paper, my impression is that the incident was meaningful to you because. . . . . . Is this how you view the significance of the incident? What about how you viewed the incident at the time?
4. How would you describe or tell of the changing influence of the incident and its long-lasting effects?

Clinical Experience Questions

5. Think about other clinical experiences. Tell me about a patient who still stands out in your mind.
6. Think back to a patient with whom you easily formed a relationship? What was that like?
7. Can you remember a patient who was difficult to care for? What was that like?
8. What does caring look like to you in your practice?
9. What would make a relationship a caring relationship?
10. Can you recall a relationship with a patient that you feel was especially caring?
11. How do you think your views about caring have changed over time?
Appendix B
Student Participation Form

If you are interested in participating in the research study, How Nursing Students Experience Caring Relationships with Patients, please complete and return this form by email to the researcher, Sandra Hoffman, at shoffma1@email at your earliest convenience but no later than March 1, 2012.

Demographic information:
Age_____ Gender_____ Option____ BSN_____ ABSN

Courses completed:

_____ Nursing 364 – Nursing Care of Adults with Major Health Problems I

_____ Nursing 470 – Public Health Nursing

_____ Nursing 472 – Nursing Care of Infants, Children and their Families

_____ Nursing 477 – Psychiatric Mental Health Concepts for Broad Clinical Application in Nursing

_____ Nursing 479 – Maternal/Newborn Nursing

Courses enrolled in:

_____ Nursing 470 – Public Health Nursing

_____ Nursing 472 – Nursing Care of Infants, Children and their Families

_____ Nursing 477 – Psychiatric Mental Health Concepts for Broad Clinical Application in Nursing

_____ Nursing 479 – Maternal/Newborn Nursing

_____ Nursing 590 – Nursing Care of Adults with Major Health Problems
Are any days of the week and times of day are best for setting up an interview?

What email address would you like me to use to contact you?

If you choose to participate in this study you will be required to submit a copy of one of your critical incident papers that you have already written for a course.

______Critical incident paper attached
______Consent form to use critical incident paper attached
Appendix C
Script for in class meeting with students

Good morning/afternoon. Your course coordinator has been kind enough to grant me some of your class time to introduce myself and explain why I am here.

My name is Sandra Hoffman and I am a doctoral student at North Carolina State University. I am also on the faculty in the School of Nursing and teach clinical in the capstone course. I am here with you today as a researcher working on my dissertation. I want to tell you about my study and invite you to participate in it.

I have taught clinical in both N364 and N590 and have come to believe that caring is an important professional value for students to learn. I believe that while there are both critical aspects to nursing and more mundane ones, a student nurse-patient relationship underpins both and enables other aspects of nursing to happen.

The title of my study is “How Nursing Students Experience Caring Relationships with Patients.” I will collect data for the study through interviews and from critical incident papers. If you want to participate in the study, you will first be asked to send me a copy of your critical incident paper and sign a consent form for me to use it as data in the study. You may also be called for an interview. Students will be chosen for the study from among those who have completed one or more clinical courses.

If you are called for an interview, the interview will take between 60 and 90 minutes and will be audiotaped. Some of the interview questions will be about the event you wrote about in a critical incident paper. All interview data will be kept confidential and your name will be removed from all study materials. The total time commitment for you will be about two hours or less. Being in the study will offer you a chance to reflect on your clinical learning and share some of your thoughts with the researcher. These reflections may offer you some personal insight into the nurse you are becoming. You will also be contributing to study findings, which may expand what we know about caring by adding descriptions of students’ caring experiences. Findings may also be helpful to nurse educators who work to support students as they learn to form caring relationships.

I hope you will consider participating in this study. I will be sending an email to you within the next week that will have a participation form and a consent form attached. If you want to participate, you will be asked to return the consent form, and return the participation form with a copy of your critical incident paper.

Thank you for your time and consideration.
Appendix D
Email to Students

I am a doctoral student at North Carolina State University. I am beginning my dissertation research and am sending this email to follow up in inviting you to participate in my study, which will explore and describe how nursing students form and maintain caring relationships with patients. I want to look at this topic through your eyes, and I am interested in hearing what you have to say about your clinical experiences.

Participating in this study will involve the submission of your critical incident paper, and may involve an interview of no more than 90 minutes. There will be questions in the interview about your critical incident and about other clinical experiences. All interview information will be audiotaped. Whatever information you share will be kept confidential. You will not be identified in any of the study materials. After the interview, I will send you your interview transcription so you can check and see that it accurately represents what you wanted to communicate.

The interviews will take place this semester. If you are interested in participating in this study, please return the attached Student Participation Form, a copy of your critical incident paper, and a signed copy of the consent form allowing me to use your paper. Send these to shoffma1@email at your earliest convenience or no later than March 1, 2012. If you have additional questions about the study, please feel free to call me at 919-308-2943.

I think the nurse-patient relationship is an important aspect of practice and I’m excited to have the opportunity to have your help in learning more about it.

I greatly appreciate your time and consideration of this request. I look forward to hearing from you soon.

Sandra Hoffman, RN, MSN
Clinical Assistant Professor
School of Nursing
Doctoral Student, NCSU
Appendix E
SCHOOL OF NURSING
OFFICE OF ACADEMIC AFFAIRS

Policy and Procedure for Accessing School of Nursing Students
For Participation in Research Projects

Preamble

The School of Nursing is committed to the conduct of research as a core component of its mission. As part of this commitment, the School will facilitate, within identified parameters, the potential participation of School of Nursing students as subjects in research projects of faculty and students in academic units at Omega University, as well as entities beyond this campus. Participation by students as subjects in a research project is always voluntary. A student’s choice whether to participate or decline will not jeopardize their academic standing in any course or program. Approval to approach nursing students in any School of Nursing program or course must be obtained by the researcher from the Associate Dean for Academic Affairs. This includes recruitment for any type of research activity, ranging from participation in a clinical study to an educational research project. IRB approval is also required and informed consent procedures designated by the IRB must be followed.

The School of Nursing will adhere to the Omega University IRB Standard Operating Procedures with regard to recruitment of students. According to the SOP, researchers generally may not solicit research subjects in their own department if it might be construed as coercive. Describing opportunities to participate in research to subjects in a subject pool, e.g., students enrolled in a School of Nursing course, is considered apprising students of opportunities to participate and not direct solicitation of subjects.

If a request to solicit human subjects in the School of Nursing is received from a non-University researcher, the researcher should first contact a University faculty sponsor as well as a Omega University IRB to ensure that Omega University students receive proper protection.

Procedure for Student Participation

The following steps must be followed for the recruitment of students and collection of data from students in approved research projects:

1. The researcher must submit a request to access students as subjects and a copy of the IRB approval to the Associate Dean for Academic Affairs before any recruitment activities take place. The request should include the plan for recruiting students and provide sufficient detail on the time commitment that would be required if classroom
time is being proposed for recruitment or data collection. The IRB approval must have been obtained from an IRB within Omega University. If approval has been obtained by a non-university researcher at another federally designated IRB (FWA or MPA), the researcher must submit evidence to a Omega University IRB for approval to recruit students on campus. This IRB approval is necessary whether data are being gathered from students on-site in the School of Nursing or if permission to recruit students is sought and the data collection or project participation will take place outside of the School of Nursing classroom setting.

2. Once the request for access and the evidence of appropriate IRB approval is submitted and reviewed for compliance with this School of Nursing requirement, the Associate Dean for Academic Affairs will contact the course coordinators of any applicable course(s) to determine their willingness to participate. Final approval to approach students will be made by the Associate Dean for Academic Affairs and the researcher will be notified of the decision.

3. The preferred approach to student recruitment is outside the context of an individual class. The Office of Academic Affairs will facilitate recruitment of students in approved projects by posting informational flyers from the investigator in the School of Nursing, distributing approved recruitment announcements prepared by the investigator to student listervs, or other similar broadcasting activities. Under no circumstances will student names be provided to investigators for contacting students directly.

4. If the researcher provides sufficient reasons for wanting to recruit students in a convened course, permission from the course coordinator must be granted to the researcher for use of class time. This permission is required either to access students as potential subjects or to gather data in a project.

5. Recruitment of students during a convened class session in any program can take place only if there is demonstrated educational value in the research focus proportional to the time needed for recruiting students in the class. This ensures that valuable class time is not taken up in a manner that will compromise meeting course objectives and covering required content.
Appendix F
Letter to Associate Dean of Academic Affairs Requesting Access to Nursing Students as Subject

Associate Dean for Academic Affairs
School of Nursing

I am a doctoral student in the department of Leadership, Policy and Adult and Higher Education at North Carolina State University. I am beginning my dissertation research and am interested in interviewing undergraduate nursing students at Omega as a part of my research. I am writing to you to submit a request to access these students as subjects.

My research is a qualitative study exploring how nursing students form and maintain caring relationships with patients. Although the nurse-patient relationship is a fundamental building block of holistic care and key to excellence in nursing practice, I find there is minimal research that discusses this experience from the student’s point of view. Information on the topic from this perspective can contribute to the profession by expanding existing nursing literature on caring and on clinical teaching and learning.

If I am allowed to use the nursing students in the School for this study, I will select 15 students as subjects. I plan 60-90 minute interviews with them. I’m also asking students to submit a critical incident paper they have written as part of a clinical course requirement, and will use these in the research. The interviews will take place early this semester. Interview questions will focus on students’ clinical experiences, including stories of what happened in their critical incidents.

I plan to recruit students in two ways: 1) by obtaining permission from course coordinators to briefly explain the study to the students in the selected cohort at the beginning of one of their classes --this introduction will take approximately 10 minutes; 2) by a follow-up email one week later, again explaining the study and inviting students to participate. The email will have a consent form and a participation form attached. If interested in participating, the students will be asked to return the participation form, their critical incident papers, and a consent form allowing the researcher to use the paper. Papers will be reviewed for stories about patient relationships, and students whose papers have these stories, will be invited to participate in interviews.

I greatly appreciate your time and consideration of this request. I look forward to hearing from you soon.
Sincerely,

Sandra Hoffman, RN, MSN
Clinical Assistant Professor
School of Nursing
Doctoral Student, NCSU
Appendix G
Recruitment flyer to be posted on bulletin boards in the School of Nursing

NURSING STUDENTS NEEDED FOR PARTICIPATION IN A RESEARCH STUDY

I am a doctoral student in the adult education program at North Carolina State University. I am doing my dissertation research. My research project is a qualitative study on how nursing students experience caring relationships with patients.

Data for the study will be collected in interviews lasting 90 minutes or less, and from critical incident papers that have already been written for a prior clinical course.

Criteria for participation in the study include completion of a clinical course and agreeing to submit a critical incident paper.

Participation in this study is voluntary. Students will remain anonymous and all data collected will be kept confidential.

If you are interested in participating in this study, please contact Sandra Hoffman, RN, MSN, Assistant Clinical Professor, for more information.

THANKS!!!
Appendix H
Contact Summary Sheet

Pseudonym_________________       Age______________
Contact date_______________       Gender___________
Today’s date_______________       BSN____ABSN_____
Course enrolled in__________

1) What event or situation(s) was involved in the critical incident(s)?

2) What story elements were evident?
   - Contingent sequences:
   
   - Characters:

   - Meaning or point to the story:

3) Which aspects of the research question did the contact discuss most centrally?
   Summarize the information

4) Anything else that struck you as salient, interesting, illuminating or important in this contact?
Appendix I
GUIDELINES FOR CRITICAL INCIDENT PAPER

Seniors are encouraged to discuss the content of their paper with clinical faculty and/or course coordinator prior to preparation. First rotation clinical faculty grade the critical incident paper. Students should choose a patient care situation related to course content.

Guidelines: Students may find it helpful to follow this outline in writing the paper, but it is not required as long as all aspects are present and easily identified in the paper. Submit two copies of the paper to clinical faculty. After grading, one copy of the paper will be returned to the senior and the other copy will be kept in the student files (undergraduate office). Clear your topic first with your clinical faculty.

I. Describe the context of the incident—tell what happened. Describe in detail all responses (these may be, for example, physiologic, emotional, behavioral, developmental, economic, organizational) of the patient, family, unit staff that are pertinent to the critical incident. Describe your personal response (feelings, concerns, thoughts) to the incident and explain why the incident was critical to your learning. Include all relevant facts about illness and hospitalization as well as any other factors important in helping the reader understand the incident. (15 points)

II. Describe patient or nursing practice problem(s) requiring intervention. Give data to support the problem; validate the defining characteristics or reason for the problem (physiological, organizational, cultural, economic, psychological/developmental factors, for example); explain why the problem requires intervention. (20 points)

III. Describe actions needed and/or actually taken; actions thought about but not taken; expected outcomes in measurable terms. Explain why interventions were chosen or not chosen. Evaluate the effectiveness of interventions implemented and discuss additional or future interventions indicated. (25 points)

IV. Provide rationale for decisions (e.g., actions/inactions require support in terms of evidence-based practice). Use research-based articles relevant to nursing that clearly relate to the incident. References should be current, published within the previous five years. Discuss how analyzing this patient or nursing practice situation will facilitate your transition to practice. (30 points)

V. Paper should be written in a narrative style that is concise, clear, and scholarly. All references used are to be cited in the text and in a reference list paper using APA format (5th edition). References should include a minimum of 3-5 current journal articles (within last 5 years) that are relevant to the incident. One web site should
also be included in the references. The length of the paper should be no more than 10 pages, typed and double-spaced. (10 Points)

EVALUATION: 10% of course grade. To pass the clinical component of Nursing 590, the senior must achieve a grade of 74 or greater on the critical incident paper. The senior whose paper does not meet the minimum of 74 will be given the opportunity to rewrite the paper. The senior is responsible for negotiating a date for submission of the rewritten critical incident paper with the clinical faculty. The maximum grade that can be achieved with a rewritten paper is 74.
Appendix J
Students’ Views on the Meaning of Caring in a Relationship

“I felt very invested in the patient. I felt connected. We had a good rapport. That made me want to advocate for her.”

“I want to do good by this patient. I think there’s definitely a caring aspect to ensuring that the person you’re charged with is receiving the standard of care. I feel a personal obligation.”

“For me, caring is a mental perspective. It’s an emotional perspective. It’s almost a way of life. I think it really is just a way of approaching relationships. . . .It’s that perspective that makes a difference.”

“If they bond with me and connect with me, then I feel like I can be caring and I could take care of them better. I think of a caring relationship as establishing it.”

“Most of the patients I’ve had I’ve felt very connected to. Caring is a part of every story. Caring is compassion and empathy.”

“Caring for me is letting patients express themselves and being a good outlet for them to express their feelings. If they can feel comfortable with you and feel like they can trust you, then they’re going to be more willing to open up and tell you what they need.”

“Everything we do is caring for the patient. And definitely patient advocacy. Being an advocate shows that you care about the patient because you want to do what’s best for the patient.”

“To me, listening is the cornerstone of caring. If you can do nothing else for the patient, you can listen to them. Even just being in the room with them and making them feel like a valuable human being is a critical piece of caring because I imagine that patients can very easily feel like another task or number.”

“I do see a connection to action. If you have a caring approach and a caring mindset but you don’t do anything, then it’s all empty. If you don’t show it then it doesn’t work.”

“Just being with, being there, being present, even if you’re not talking. Just being with someone.”

“I think for me caring is taking the time to be with your patient in whatever way that manifests for the person. I think caring can mean advocacy.”
“For me, caring is making the effort to try to make things better for someone else – not just with what’s going on in the hospital but what’s going on in their lives, too.”

“I know what I am feeling on the inside but caring is also seeing something like I feel is not happening [with a patient] that should be happening.”

“I think for me it’s really about giving the person what they need in that moment. . . not every patient wants all the care you can provide. It’s up to that person to decide whether they want to receive that or not, and it’s not for us to pass judgment that they’re refusing this care or that care. I think it really needs to be about the person’s goal and what they want.”

“When I think of true caring, I think of selflessness and I think of love, not in the same sense that we normally think of love, but just like connections and really seeing a person for who they are. . . . .Because I don’t know how you could see a person for why they truly are and not want to be there for them and not want to help them with whatever’s going on with them. I think that, to me, is caring.”
Appendix K
North Carolina State University
Institutional Review Board for the Use of Human Subjects in Research
SUBMISSION FOR NEW STUDIES

GENERAL INFORMATION

1. Date Submitted: _____
   1a. Revised Date: _____

2. Title of Project: How nursing students experience a caring relationship with patients

3. Principal Investigator: Sandra R. Hoffman

4. Department: Leadership, Policy and Adult and Higher Education

5. Campus Box Number: none

6. Email: shoffma1@email

7. Phone Number: 919-308-2943

8. Fax Number: none

9. Faculty Sponsor Name and Email Address if Student Submission: Dr. Carol Kasworm and Dr. Kathy Lohr
   carol_kasworm@ncsu.edu; kathy_lohr@ncsu.edu

10. Source of Funding? (required information): none

11. Is this research receiving federal funding?: no

12. If Externally funded, include sponsor name and university account number:

13. RANK:
   
   - Faculty
   - Student: Undergraduate; Masters; or PhD
   - Other (specify): EdD

As the principal investigator, my signature testifies that I have read and understood the University Policy and Procedures for the Use of Human Subjects in Research. I assure the Committee that all procedures performed under this project will be conducted exactly as outlined in the Proposal Narrative and that any modification to this protocol will be submitted to the Committee in the form of an amendment for its approval prior to implementation.

Principal Investigator:

Sandra Hoffman

(typed/printed name) (signature) (date)

As the faculty sponsor, my signature testifies that I have reviewed this application thoroughly and will oversee the research in its entirety. I hereby acknowledge my role as the principal investigator of record.

Faculty Sponsor:

Carol Kasworm
Kathy Lohr

(typed/printed name) (signature)

*Electronic submissions to the IRB are considered signed via an electronic signature. For student submissions this means that the faculty sponsor has reviewed the proposal prior to it being submitted and is copied on the submission.
Please complete this application and email as an attachment to: debra_paxton@ncsu.edu or send by mail to: Institutional Review Board, Box 7514, NCSU Campus (Administrative Services III). Please include consent forms and other study documents with your application and submit as one document.

For SPARCS office use only

Reviewer Decision (Expedited or Exempt Review)

☐ Exempt  ☐ Approved  ☐ Approved pending modifications  ☐ Table

Expedited Review Category: ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8a  ☐ 8b  ☐ 8c  ☐ 9

Reviewer Name
Signature
Date

North Carolina State University
Institutional Review Board for the Use of Human Subjects in Research
GUIDELINES FOR A PROPOSAL NARRATIVE

In your narrative, address each of the topics outlined below. Every application for IRB review must contain a proposal narrative, and failure to follow these directions will result in delays in reviewing/processing the protocol.

A. INTRODUCTION

Briefly describe in lay language the purpose of the proposed research and why it is important.

The purpose of this study is to explore and describe how undergraduate nursing students experience caring relationships with patients.

The American Association of Colleges of Nursing (AACN) standards for the preparation of baccalaureate nursing students for practice. This regulatory body specifies that graduate nurses be prepared to practice within a holistic, caring framework. AACN also explicate the meaning of caring as a professional value. Yet in spite of theoretical information on the importance of caring in nursing and on how caring informs practice, there is minimal research that examines caring from the perspective of the nursing student who learns the meaning of caring experientially in the context of working with patients. More information is needed about how the formation of this central building block of holistic practice actually happens experientially for students. Addressing the lack of information about the realities of students’ understandings of and experience with forming and being in caring student nurse-patient relationships can help practice by expanding the existing theoretical literature on caring with actual descriptions of what caring is like for a nursing student. Research on caring, as seen through the eyes of nursing
students, can help educators understand the formation of students’ attitudes and beliefs about forming caring relationships, and how these attitudes and beliefs inform their behaviors and developing identities. Understanding the contextual nature of students’ caring relationships can help nurse educators support students in the development of relational and communications skills needed to keep the patient at the center of care.

1. If student research, indicate whether for a course, thesis, dissertation, or independent research.

   dissertation

B. SUBJECT POPULATION

1. How many subjects will be involved in the research?
   Estimates or ranges are acceptable. Please be aware that if you recruit over 10% more participants than originally requested, you will need to submit a request to modify your recruitment numbers.

   15 subjects

2. Describe how subjects will be recruited. Please provide the IRB with any recruitment materials that will be used.

   Subjects will be recruited according to Omega University School of Nursing’s Policy and Procedure for Accessing School of Nursing Students for Participation in Research Projects. After obtaining approval from the School, the researcher will visit the classes in which subjects are enrolled, explain the purpose and design of the study, what the study can contribute, and time required by the student. She will request student participation and inform students she will send a follow-up email with a week with a participation form. The researcher will also request the Office of Academic Affairs at the School to post flyers explaining the study throughout the School. Within one week of visiting classes to introduce the study, the researcher will send a follow-up recruitment email to the same students. A participation form and a consent form will be included in the email. Interested students will be asked to return the participation form to the researcher. From the pool of students who return the participation form, subjects will first be selected from among students who have completed three courses with a clinical component. If students are needed in addition to interested students who have completed the three courses, students who have completed one course with a clinical component will then be recruited.
3. List specific eligibility requirements for subjects (or describe screening procedures), including those criteria that would exclude otherwise acceptable subjects.

Eligibility requirements include: 1) enrolled in the undergraduate bachelor of science in nursing (BSN) or accelerated bachelor of science in nursing (ABSN) option; 2) completed at least one course with a clinical component; 3) have had no prior interaction with the researcher; 4) agree to submit their critical incident paper to the researcher for review.

4. Explain any sampling procedure that might exclude specific populations.

None

5. Disclose any relationship between researcher and subjects - such as, teacher/student; employer/employee.

The researcher is on the faculty in the School of Nursing but has not had any interactions with the subjects.

6. Check any vulnerable populations included in study:

- [ ] minors (under age 18) - if so, have you included a line on the consent form for the parent/guardian signature
- [ ] fetuses
- [ ] pregnant women
- [ ] persons with mental, psychiatric or emotional disabilities
- [ ] persons with physical disabilities
- [ ] economically or educationally disadvantaged
- [ ] prisoners
- [ ] elderly
- [ ] students from a class taught by principal investigator
- [ ] other vulnerable population.

7. If any of the above are used, state the necessity for doing so. Please indicate the approximate age range of the minors to be involved.

C. PROCEDURES TO BE FOLLOWED

1. In lay language, describe completely all procedures to be followed during the course of the experimentation. Provide sufficient detail so that the Committee is able to assess potential risks to human subjects. In order for the IRB to completely understand the experience of the subjects in your project, please provide a detailed outline of everything subjects will experience as a result of participating in your project. Please be specific and include information on all aspects of the research, through subject recruitment and ending when the subject's role in the project is complete. All descriptions should include the informed consent process, interactions between the subjects.
and the researcher, and any tasks, tests, etc. that involve subjects. If the project involves more
than one group of subjects (e.g. teachers and students, employees and supervisors), please make
sure to provide descriptions for each subject group.

1) The study will be explained in detail to potential participants through an in
class meeting and in an email. 2) Students who are interested in participating
will return the participation form sent as an attachment to the email and will also
send their critical incident paper by email to the researcher. 3) If more than 15
students indicate an interest in the study, those students not selected will be
thanked for their interest, and notified that the sample quota had been reached.
4) An interview time will be set up with each student. 5) After the student signs
the consent form, an audio-taped interview lasting up to 90 minutes will be held.
6) Interview transcripts will be sent to students for their review. 7) Students
will have the option to modify transcripts if they do not feel the transcript
accurately reflects what they intended to communicate to the researcher.

2. How much time will be required of each subject?
The total time commitment will be approximately two hours.

D. POTENTIAL RISKS
1. State the potential risks (psychological, social, physical, financial, legal or other) connected with
the proposed procedures and explain the steps taken to minimize these risks.

Because students will be asked to talk about critical incidents, recall and
discussion of events that happened and actions taken or not taken during clinical
experiences can potentially cause some psychological distress for students if
these happenings have been problematic or caused some internal conflict for the
student. Students will have the option to disclose only what they are
comfortable talking about, can decide not to discuss a difficult issue, discontinue
a discussion at any point, or, if they wish to discuss an issue, will be given an
opportunity to do so. If any psychological or emotional distress should
accompany any conversations in the interviews is causing severe distress to a
student, the student will be encouraged to contact Counseling and Wellness
Services. Students will be assured their interview information will be kept
confidential and their anonymity ensured.

2. Will there be a request for information that subjects might consider to be personal or sensitive (e.g.
private behavior, economic status, sexual issues, religious beliefs, or other matters that if made
public might impair their self-esteem or reputation or could reasonably place the subjects at risk of
criminal or civil liability)?

no
a. If yes, please describe and explain the steps taken to minimize these risks.

2. Could any of the study procedures produce stress or anxiety, or be considered offensive, threatening, or degrading? If yes, please describe why they are important and what arrangements have been made for handling an emotional reaction from the subject.

Interview questions about critical incidents could potentially cause students to remember difficult events. If students experience undue distress in talking about any of these events, they will be referred to Counseling and Wellness Services.

3. How will data be recorded and stored?

Interview data will be audiotaped and securely stored electronically on the researcher’s personal computer. Field notes will be taken after each interview to provide data the researcher feels may add important context for the interview data. After field notes are reviewed, a contact summary sheet will be created for each subject. Participant data forms, field notes, contact summary sheets, and the students’ critical incident papers will be stored securely in the home of the researcher.

a. How will identifiers be used in study notes and other materials?

Pseudonyms will be given to each of the subjects in all written materials.

b. How will reports will be written, in aggregate terms, or will individual responses be described?

Because this is a qualitative study, individual responses will be described. Personal information will not be included.

4. If audio or video recordings are collected, will you retain or destroy the recordings? How will recordings be stored during the project and after, as per your destruction/retention plans?

Audio taped interview data will be securely stored electronically on a password protected computer. The audiotape recordings will be deleted at the conclusion of the dissertation process, after the final defense has been completed and any required corrections made to the final dissertation document.

5. Is there any deception of the human subjects involved in this study? If yes, please describe why it is necessary and describe the debriefing procedures that have been arranged.

There will be no deception of human subjects in this study.
E. POTENTIAL BENEFITS

This does not include any form of compensation for participation.

1. What, if any, direct benefit is to be gained by the subject? If no direct benefit is expected, but indirect benefit may be expected (knowledge may be gained that could help others), please explain.

Students may benefit by gaining personal insights into what they perceive a caring relationship with a patient to be. These insights may positively influence self-esteem as students realize they are able to form and maintain caring relationships and are developing in their role as holistic practitioners. Telling a story to an interested listener can also increase self-esteem. Being heard sends a message to the student that he or she is valued. Students may benefit by knowing they are contributing to a study where findings may illuminate an aspect of student experiential learning and help nurse educators better understand how to support student efforts in building relationships.

F. COMPENSATION

Please keep in mind that the logistics of providing compensation to your subjects (e.g., if your business office requires names of subjects who received compensation) may compromise anonymity or complicate confidentiality protections. If, while arranging for subject compensation, you must make changes to the anonymity or confidentiality provisions for your research, you must contact the IRB office prior to implementing those changes.

1. Describe compensation

No compensation is involved in this study.

2. Explain compensation provisions if the subject withdraws prior to completion of the study.

3. If class credit will be given, list the amount and alternative ways to earn the same amount of credit.

G. COLLABORATORS

1. If you anticipate that additional investigators (other than those named on Cover Page) may be involved in this research, list them here indicating their institution, department and phone number.

No participation by additional investigators in anticipated.
2. Will anyone besides the PI or the research team have access to the data (including completed surveys) from the moment they are collected until they are destroyed. A transcriptionist will have access to the interview data. Subjects will have access to their own data after it has been transcribed and sent to them for member checks. My dissertation advisors will have access to the data as well as a designated peer reviewer.

H. CONFLICT OF INTEREST
1. Do you have a significant financial interest or other conflict of interest in the sponsor of this project? no

2. Does your current conflicts of interest management plan include this relationship and is it being properly followed? ____

I. ADDITIONAL INFORMATION
1. If a questionnaire, survey or interview instrument is to be used, attach a copy to this proposal.

2. Attach a copy of the informed consent form to this proposal.

3. Please provide any additional materials that may aid the IRB in making its decision.

J. HUMAN SUBJECT ETHICS TRAINING
*Please consider taking the Collaborative Institutional Training Initiative (CITI), a free, comprehensive ethics training program for researchers conducting research with human subjects. Just click on the underlined link.
Appendix L
North Carolina State University
INFORMED CONSENT FOR RESEARCH

Title of study: How Nursing Students Experience Caring Relationships with Patients

Principal Investigator: Sandra Hoffman  Faculty Sponsors: Dr. Carol Kasworm; Dr. Kathy Lohr

What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate, or to stop participating at any tie without penalty. The purpose of research studies is to gain a better understanding of a certain topic or issue. You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those that participate. In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the researcher for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher named above.

What is the purpose of this study?
The purpose of this study is to explore and describe how nursing students experience caring relationships with patients.

What will happen if you take part in the study?
If you agree to participate in this study you will be asked to: 1) Return the participation form and email a copy of your critical incident paper to the researcher. 2) Sign the consent form. 3) Participate in an interview of up to 90 minutes in which you will be asked to talk about clinical experiences including what happened in the critical incident you wrote about. Interviews will be held in the School of Nursing at a time that is convenient for you. 3) You will have the opportunity to review a transcript of your interview to be sure it accurately reflects what you intended to say.

Risks
Recalling and talking about your critical incident or other clinical experiences could possibly stir feelings of conflict or discomfort in you. You will have the option during the interview of declining to talk about any subject that you find particularly distressing. You will also have the option to not complete any part of the interview and to have any part of the interview not recorded if you want to talk without being recorded. You may also terminate the interview at any time.
**Benefits**
Possible benefits to you of participating in the study are greater self-awareness of your ability to form caring relationships with patients. This awareness can be empowering in enabling you to see yourself as a developing holistic practitioner. You may benefit by reflecting on what you learned from past experiences and how that learning is influencing your current clinical experiences. Your participation may also help nurse educators better understand how to support students in forming caring relationships.

**Confidentiality**
The information in the study records will be kept confidential. Data will be stored securely in the home office files of the researcher. No one else has access to this office. Interviews will be audiotaped and the stored electronically on a password protected computer. Transcripts will be stored in a secure file belonging to the researcher. The audio recordings will be deleted at the conclusion of the dissertation process, after the final defense has been completed and any required corrections have been made to the final document. No reference will be made in oral or written reports, which could link you to the study. Individual responses will be used in reports about this research, but personal information will not be reported.

**Compensation**
You will not receive any compensation for participating in this study.

**What if you have questions about this study?**
If at any time you have questions about the study, you may contact the researcher, Sandra Hoffman.

**What if you have questions about your rights as a research participant?**
If you feel you have not been treated according to the description of study procedures presented in this form, or that your rights as a participant have been compromised, you may contact Debra Paxton, Regulatory Compliance Administrator, Box 7514, North Carolina State University, 919-515-4514 or email debra_paxton@ncsu.edu.

**Consent to participate**
I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may withdraw from the study at any time.

Subject’s signature__________________________________________________________
Date__________________

Investigator’s signature______________________________________ Date_____________