To Err is Human:
A Phenomenological Study of the Meaning of Mistakes as
Experienced by Psychiatric Nursing Instructors
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Abstract

From error to error one discovers the entire truth.

- Sigmund Freud

This phenomenological study explored the essence of the meaning that the experience of making mistakes holds for 6 psychiatric nursing instructors in a psychiatric nursing school in a large urban area in Canada. Discussion of making mistakes in the health care field is often a taboo subject, yet learning theory suggests the best way to develop good judgment is to learn from mistakes (Berman, 2006). Data collected from face to face interviews and an on-line focus group was analyzed to determine themes of meaning and the contexts in which they occurred. It was found that, consistent with the literature, not only did all six psychiatric nursing instructors view mistakes as critical to the learning process, they also had a thirst to talk about the phenomena of mistake making. Additionally, some of the impact of the phenomena on psychiatric nursing students learning experiences emerged, contributing to a deeper understanding of the phenomena for the field.

Keywords: Nursing education, mistakes, errors, student learning, nursing, psychiatric.

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A subtle thought that is in error may yet give rise to fruitful inquiry that can establish truths of great value.

- Isaac Asimov

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Mistakes are not sins…The discovery of negative aspects and limitations in your self should not be seen as something evil. They are part of the perfection of life.

One half of the unit. Without knowing the darkness of night, the light of day is not enjoyed (Swami Sivananda Radha, 985, p. 15).

I have been blessed with many teachers on my road of discovery. The first to acknowledge is my mother, Shirley Daventry French, who besides giving me birth, also had the good fortune to meet Carole Miller while both were embarking on their own journeys to explore the darkness of their night. That exploration led them to Swami Sivananda Radha and B.K.S. Iyengar, and as anyone who has had the privilege to grace their shadows knows, if you spend any time with them, you will come face to face with your sins. Facing my sins has allowed me to take the risks necessary to embark on the academic journey of discovery encased in these covers. In fact, it also gave me the inspiration for this project as I discovered my focus in the bookstore at Swami Radha’s ashram while on a retreat studying with B.K.S.Iyengar’s daughter Geeta.

With Carole’s encouragement I pursued my wish to study in the EDCI department, meeting Dr. Kathy Sanford. Dr. Sanford was willing to welcome a nurse into the EDCI fold, and gave me the freedom I needed to follow a somewhat atypical path, and for that I am extremely grateful. Her feedback and support has been invaluable. I also had the good fortune to study with several master teachers – Dr. Lee Ellis, Dr. Wanda Hurren, Dr. Jennifer Thom, Dr. Deborah Begoray, Dr. Roy Graham and Dr. Peter O’Connor – who taught me more by how they taught, then what they taught, although the content also proved very helpful. Thank you pointing me toward the light. Namaste
Chapter One

Freedom is not worth having if it does not connote freedom to err. It passes my comprehension how human beings, be they ever so experienced and able, can delight in depriving other human beings of that precious right.

- Mohandas K. Ghandi

Introduction and Overview

Purpose of the study. The purpose of this phenomenological study is to describe the essence of the meaning that the experience of making mistakes holds for psychiatric nursing instructors at a nursing school in a large urban area in Canada.

The term mistake will generally be defined as "a state of tension that occurs whenever a person holds two cognitions (ideas, beliefs, opinions) that are psychologically inconsistent" (Tavris & Aronson, 2007, p. 13), resulting in dissonance. The definition is not exclusive of the common understanding of mistakes as "a misconception about the meaning of something; a thing incorrectly done or thought; an error of judgement" (Oxford, 2002, p. 1797) that result from the choices a person makes (Crigger, 2004), but nor is it confined to it. Regardless of whether mistakes arise out of a tense cognitive state, a misconception of knowledge, or choosing the wrong rule to follow, for the purposes of this study, as described by Crigger (2004), it will be assumed that mistakes are unintentional; are independent of outcome (e.g. harm vs no harm); involve being able to choose between alternative options; and are accidental, unforeseen events.

What can constitute a mistake in a psychiatric setting goes beyond the usual concerns about medication and procedural errors that occur when providing health care. Psychiatric nursing is founded on the therapeutic use of self (Shea, 1998). Failure to
establish rapport through a trusting and respectful relationship that utilizes empathy can have far reaching adverse effects resulting in failure to effectively engage clients (Shea, 1998). Lack of engagement prevents psychiatric nurses from establishing and maintaining the therapeutic alliance needed to glean critical assessment data that allows psychiatric nurses to promote not only a client's well being, but also their safety and security (Shea, 1998). Communication errors such as failure to utilize empathy, and being disrespectful, impatient or judgmental, lead to client resistance and alienation resulting in avoidance of treatment. Failure to effectively engage psychiatric clients only puts the client at risk (e.g. failure to accurately assess psychosis or suicidal intent), but is also frustrating, and potentially dangerous for, family members who must endure the client's suffering or in rare circumstance, threatening behaviour.

**Background of the study/rationale.** The journey that led to embarking of this project, the meaning of mistakes, started 25 years ago when I entered nursing school. My experiences in nursing school lead me to vow upon graduation that I was never going to become a nursing instructor. Since starting to teach as a psychiatric nursing instructor seven years ago I have pondered often what it was about nursing school that caused me to make such a declaration. I didn't have to look too far to discover that some of the practices that made me swear I would not engage in teaching psychiatric nursing were still occurring. The following statements by two psychiatric nursing students demonstrate that there is still much work to be done to addressing what Freire (1970) refers to as horizontal violence: "I found some of the instructors to be very difficult and even threatening, singling out individuals and being quite nasty to them. It was not a very
nurturing environment." (Anonymous, 2007, p. 6); "It would have been better to have the instructors teach in a way that is respectful." (Anonymous, 2007, p. 6).

I then considered what might be at the root of some of the horizontal violence. I explored the nature and impact of horizontal violence from a variety of angles as I progressed through my Master's degree. I considered how my own psychiatric nursing and teaching experiences have been shaped by it and came to the conclusion that many of the practices and ways of relating that have evolved are deeply rooted in the high levels of anxiety psychiatric nursing instructors experience trying to mould their students into the consummate professionals they are expected to become. And if there is one area that strikes the most fear into many a nursing instructor's heart, it is that they or their students will make mistakes in clinical settings, leading to the harm of clients.

It also became clear, as I discussed this idea with some of my colleagues, that there was a thirst to find a forum to have a discussion about what mistakes mean, how they impact learning, the influence they have on instructor and student relationships, and student's growth and development as health care professional. As one of my subjects stated at the end of her interview:

This is an excellent topic, it is a very timely topic and I know it is one for me and one I just went through with a student...the student said to me, "DB, you know, it was really good we talked about this because as students we are always worried, Oh My God, what is going to happen when we make a mistake, 'cause nobody talks about it, nobody tells us what is going to happen, so we are always walking around thinking, when someone fails, Oh My God, did they make a mistake, what happened?"
It is my hope that the discussion I have embarked on with six of my colleagues will be the first of many explorations of how mistakes are experienced by psychiatric nursing instructors so that we can leave the vestiges of horizontal violence behind, embarking on a journey with our students that promotes mistake making as the learning opportunity we all assert it is meant to be.

**Anticipated outcomes.** Encouraging reflection on the meaning of mistakes, regardless of whether they occur in the safety of the classroom, or in situations with potentially adverse consequences for clients, is the precursor to promoting an atmosphere where mistakes can be acknowledged, learned from, and when possible, corrected. If one accepts the wisdom of the statement by John F. Kennedy that "an error does not become a mistake until you refuse to correct it" (Tavris & Aronson, 2007, p. 218), promoting a safe, supported atmosphere in which mistakes can be examined and rectified benefits all potentially affected parties be they nursing instructors whose license covers their students' practice, the students, the clients, the institutions in which health care is delivered, and the wider society who can be assured their health professionals are the most competent and caring available. Exploring the meaning that mistakes hold for psychiatric nursing instructors will therefore have two main benefits. First, a greater appreciation of how making mistakes impacts psychiatric nursing student's learning experiences may emerge. Second, increasing awareness amongst instructors of the need to promote a safe, supportive environment for that exploration may lead to changes in current practices that tend to discourage openness about errors.

**Considerations.** Several issues related to the design of this study need to be considered. Van Manen (1990) argues that the bracketing out, or epoche, built into the
design of this study in order to reduce the researchers bias is impossible to actually achieve, nor does he feel it is necessarily desirable. Phenomenology is research that Van Manen describes as a caring act that investigates phenomena close to the researcher's heart (1990). The notion that bias should thus be eradicated runs the risk of reducing the thoughtfulness and awareness of subjectivity required to conduct phenomenological research and increases the risk of engaging in objective detachment far removed from the lived experience of those experiencing the phenomena. Traditional approaches, which rise out of a positivist paradigm, rely heavily on utilitarian methods such as "describing, explaining, predicting and controlling " (p. 569), reflect a philosophy that supports a hierarchical approach to learning immersed in rules and preconceived outcomes (Wilson-Thomas, 1995). In a positivist paradigm technical skills are valued more than interpersonal skills (Fletcher, 2006), hardly an effective approach for dealing with the complexities of the human experience (Wilson, 2001), which are the cornerstone of psychiatric nursing, and this study. Gillespie (2002) points out that the kind of practices that focus on competence without compassion are in fact brutal. Rather than bracketing out, other authors suggest that a more useful way of thinking about the epoche is to view it as a way of temporarily putting on hold previous held ideas in an endeavour to foster greater curiosity (Creswell, 2007; LeVasseur, 2003), which is what I have endeavored to do.

An additional consideration is the small sample size that doesn't allow for generalizability of the findings –although Van Manen (1990) suggests this is not a goal given the inherent uniqueness of the human experience. The participants were self-selected. Those too uncomfortable or unwilling to admit and discuss their mistakes would
have excluded themselves. They were all white females over a certain age who would be considered privileged within our society. They were all experienced faculty members working in the same department. Literature points out that those with less experience are exposed more often to the sequelae of horizontal violence and its influence on mistake making (Kroll, Singleton, Collier & Rees Jones, 2008), thus they may experience the phenomena differently, and therefore any findings must be cautiously applied when working with them. All these factors suggest that the instructors participating may not represent a diverse range of perspectives on the experience of making mistakes and that more research needs to be done in a wider range of settings drawing more randomly from a larger applicant pool to increase the chance of hearing divergent viewpoints.
Chapter Two

A man travels many miles to consult the wisest guru in the land.

When he arrives, he asks the wise man: "Oh, wise guru, what is the secret to a happy life?"

"Good judgment," says the guru.

"But oh, wise guru," says the man, "how do I achieve good judgment?"


Literature Review

Discussion of making mistakes in the health professions has until recently, been a very taboo subject (Tavris & Aronson, 2007). Yet, health professionals, being human, do make mistakes, in not infrequent nor isolated fashion (Crigger, 2004; 2005; Kroll et al., 2008; Ziv, A., Ben-David, & Ziv, M., 2005). This contradicts the myth that health care professionals should be infallible (Crigger & Meeks, 2007; Tavris & Aronson, 2007, Tschudin, 1998). However, in situations where health care professionals recognize and acknowledge mistakes, not only are they perceived as more competent, committed and caring, the incidence of malpractice lawsuits is actually reduced (Tavris & Aronson, 2007; Ziv, et al., 2005). In spite of this changing climate, psychiatric nursing instructors continue to experience very high levels of anxiety around the issue of making mistakes (Gillespie, 2002). Given that making mistakes is a precursor to learning (Berman, 2006; Neilsen, 2007; While, 2003; Ziv, et al., 2005), it is of paramount importance that psychiatric nursing instructors become more comfortable with the dissonance errors in cognition and deed invoke. Also at issue is the nature of instructor-student interactions which frequently fail to promote a safe environment within which students can explore
mistakes and their implications (Diekelmann, 2005; Gillespie, 2002; Salmon & Keneni, 2004).

Tavris and Aronson (2007) tell the story of a young IBM executive who became involved in a high-risk venture and lost $10 million dollars of the company's money. The young man came to the meeting with his boss and offered his resignation. Instead of accepting it, his boss responded, "You can't be serious. We've just spent $10 million educating you." (p. 225). The boss in this particular situation supports the notion expressed by the guru quoted above, yet why was the young executive surprised about this reaction? Tavris and Aronson suggest it is because North American culture equates making mistakes with being stupid rather than with being an event that supports growth, development and learning. The consequence of such a belief is that instead of examining mistakes, they are ignored, preventing the individual learning from them. Berman (2006) emphasizes that efforts to try and conceal rather than examine mistakes often exacerbates the consequences causing mistakes to take on "disastrous proportions" (p. 115), which in the health professions can prove not only harmful, but deadly, for the recipient. Our cultural aversion to acknowledging errors suggests too many errors go unaddressed (Kroll et al., 2008; Tavris & Aronson, 2007). On the other hand, Tavris and Aronson cite several reasons that acknowledging mistakes is beneficial: you may be found out anyways and therefore it is better to admit the mistake than be exposed; it will ensure you are held in better esteem by other people; someone else may be able to help find a solution to the dissonance of holding two divergent cognitions (e.g. you learn from it); and it sets a good example for others. In the health care field admitting and examining errors promotes not
only learning but enhances quality of care and client safety (Kroll et al., 2008; Ziv et al., 2005)

Numerous authors describe mistake making as part of the human condition and essential to the learning process (Berman, 2006; Crigger, 2004; Kroll et al., 2008; Nielsen, 2007; Tavris & Aronson, 2007; While, 2003; Ziv et al., 2005). Others point out that mistakes are unavoidable (Berman, 2006; Crigger, 2005; Crigger & Meek, 2006; Kroll et al., 2008; Reason, 1990; Schon, 1987; Tavris & Aronson, 2007; While, 2003; Ziv et al., 2005). However, Berman outlines what he calls a paradox of clinical teaching – mistakes by students and their instructors are unavoidable, yet due to the professional nature of clinical work, clients expect that mistakes will not be made, or if they do occur, will do no harm. The challenge facing instructors is how to protect clients while promoting an atmosphere of discovery that allows mistakes to be examined and learned from (Berman, 2006). As Berman (2006) states, not only can mistakes result in disaster, but also discoveries of great significance.

The goal of learning from mistakes is both to prevent them recurring, and manage the consequences when they occur. Dewar and Walker (1999) suggest that examining mistakes is a sign of a mature professional who is willing to learn from what went wrong. Berman (2006) asserts that the process of learning how to mitigate and manage mistakes needs to be a part of all professionals' education. Before this can happen however, it is necessary to understand what mistakes are, no small undertaking as they are not only often highly complex in nature, but also culturally construed (Crigger, 2004). It is the culture that determines those activities worthy of notice and it is the culture that defines the bar for perfection against which imperfection can be measured (Crigger, 2005). The
culture establishes the rules and standards based on "the truth" as it is understood in that particular time and place, and then applies these standards to specific circumstances and individuals (Crigger, 2005). Mistakes are thus defined by cultural consensus (Crigger, 2004) – the implications of this for health care practitioners will be made clear later in this discussion.

Mistakes generally can be categorized by whether they are an act of omission - failure to carry out the act, or commission – carrying out the wrong act (Lee 2002). They can be further broken down into mistakes of underuse – not following established practice; misuse – an act of bad judgment; and overuse - carrying out an act too much or too often (Lee, 2002). Reason (1990) describes two basic types of errors: slips and lapses, and mistakes. Slips and lapses occur when what was intended is not what was actually done (Reason, 1990). Further, a slip entails a failure to carry out an act whereas a lapse entails actually forgetting to do it: both are what Reason describes as failures of execution, or mistakes of omission. Mistakes, on the other hand, occur when the intended act does not bring the expected results, what Reason refers to as a failure in planning or a mistake of commission. Another distinction is that slips and lapses occur outside of the person's awareness, whereas mistakes arise from bad judgment which arises from lack of experience and an inadequate knowledge base (Reason, 1990).

To complicate matters further, Reason suggests that the above explanation does not adequately elucidate what happens when errors result from a combination of slips and mistakes (1990). Reason thus developed GEMS – the generic error modeling system - which describes three errors in cognitive reasoning: skill-based slips; rule-based mistakes; and knowledge-based mistakes. Skilled-based slips occur when routine tasks
which involve low levels of problem solving are carried out automatically and go awry (Reason, 1990). These are errors that occur in what Schon (1987) terms the 'knowing–in action' domain and are generally slips, lapses or errors of omission. Rule-based mistakes involve choosing to apply the wrong principle or rule to a given situation and require higher levels of knowledge application and problem solving in order to alter outcomes (Reason, 1990); they are acts of commission. Lastly, knowledge-based errors occur when there is an inadequate knowledge base or an inaccurate assessment is made of the situation (Reason, 1990). Circumstances arise that are novel or without precedence and require large amounts of critical thinking to resolve, and errors, which occur frequently in the knowledge based realm, result due to lack of preparation – a failure to plan (Reason, 1990). Management of the mistake is done through trial and error and how well it is resolved is dependent on professional expertise or judgment (Reason, 1990), and I would argue, morality, of the individual making the error.

Both rule-based and knowledge-based mistakes require engaging in what Schon (1987) describes as ‘reflection in action’ – consciously adapting and making changes while still in the middle of the activity, not just through application of previously acquired knowledge. It is through “reflection in action,” Schon argues, real learning that involves the critical thinking necessary to become an expert or professional occurs. Schon advocates for reflective practicums in the knowledge-based realm where learning from mistakes is maximized while their consequences are minimized. Reason (1990) postulates that learning in the knowledge-based realm will allow students to start to develop the expertise that will allow them to function more often outside of it, in what Schon calls the critical zone, where mistakes occur less often due to the practitioner having a much
greater repertoire of knowledge and problem solving strategies. Even when operating from inside the knowledge-based realm, experts make fewer mistakes due to their higher level of critical reflection skill, what Dewey (1916) calls "reflective experience" – whereby critical thinking is employed to "make a backward and forward connection between what we do to things and what we enjoy or suffer from things in consequence" (p. 74). Students reflect, test out their hypothesis, and develop new ways of resolving the challenge before them (Schon 1987).

Heidegger argues that the intellectual or academic focus on learning from mistakes described above that relies on knowledge or cognition does not go far enough as it doesn't account for our humanness (Nielsen, 2007). Heidegger asserts that practical understanding does not arise from an intellectual abstract representation of knowledge but rather "our being in the world," (p. 457) and "it is through our dealings with the world we come to know it" (p. 457) by manipulating the equipment or objects that surround us (Neilsen, 2007). It is through using the equipment, rather than reflection, that learning takes place, a process Heiddegger calls circumspection (Neilsen, 2007). Through circumspection "an active person looks around when using equipment and understands the use of a particular piece of equipment from how it relates to the totality of the equipment" (Neilsen, 2007, p. 459). Unlike Schon (1987), who argues that learning occurs first out of context with no loss of the complexity of the circumstances, Heidegger suggests this would only work in straightforward or simple situations such as mistakes of omission at the skill-based level (Neilsen, 2007). While both recognize mistakes as a precursor for learning, Schon sees a mistake as an opportunity to consider new ways of understanding what is immediately before the practitioner, Heidegger asserts it also
"changes our way of being in the world, and not merely the way we reflect on our being in the world" (Neilsen, 2007, p. 465). The latter approach recognizes that mistakes don't necessarily occur in isolation or to individuals, but as part of a complex process that has an impact on the surrounding world and can lead to a greater understanding of that world (Neilsen, 2007), a sentiment that supports the idea that mistakes have cultural implications.

Given all the benefits in terms of the learning process, and the potentially disastrous consequences of failing to address mistakes, in thought and deed, in a health professional setting, one would think it behooves psychiatric nurse educators to ensure that an atmosphere be created that encourages their students to acknowledge and learn from their mistakes. Alas, this has at times, not been my experience, either as a student of nursing over 20 years ago, nor as a psychiatric nursing instructor for the last 7 years. As the following quotes demonstrate it is also not the experience of many psychiatric nursing students: "The majority of instructors were not respectful or fair with the students." (Anonymous, 2007, p. 6); "The school can be a threatening and intimidating environment." (Anonymous, 2007, p. 6); “The instructors did not treat everyone equally, and sometimes tried to use scare tactics on the students." (Anonymous, 2007, p. 6).

Several nurse researchers have demonstrated that a supportive, caring, respectful instructor-student relationship is paramount if students are to be encouraged to acknowledge not only errors in clinical settings, but also subject their thinking to critical reflection (Diekelmann, 1992; 2004; 2005; Gillespie, 2002; Salmon & Gutema, 2004; Schreiber & Banister, 2002). Tschudin (1998) adds that instructors must be willing to have their own "moral behaviour challenged" (p. 55) and be open to incorporating new
knowledge, in order to establish effective relationships with students from which "the art of caring for vulnerable and suffering people" (p. 55) can emerge.

Unfortunately, as the students quoted above demonstrate, this often does not manifest in actual psychiatric nursing educational settings. The cultural consensus is that mistakes can't happen and if they do it is the individual's fault. All too often we succumb to the culture of blame and shame that leaves those who make mistakes feeling isolated, fearing the punitive consequences of disclosure such as loss of self esteem, integrity, confidence or their actual job, in what amounts to an often threatening and oppressive and bullying hierarchal system (Crigger, & Meeks, 2005; Kroll et al, 2008). Oppression is defined by Kendall (1992) as an ideology that "is an integrated pattern of ideas, a system of beliefs that characterizes unequal relations in a social system by use of power" (p. 4). Oppressed individuals or groups have less power, status, autonomy, control, and accountability than those in the dominant group who are the oppressors (Bent, 1993; Fletcher, 2006; Freire, 1970). Value is placed on the characteristics, knowledge and ideology of the oppressor; those of the oppressed are viewed as less desirable or negative (Bent, 1993; Freire, 1970). The oppressed, due to their lack of power, tend to internalize the values of the oppressors, leading to marginalization (Bent, 1993; Fletcher, 2006; Freire, 1970). Rewards are given to those who conform; deviation results in unpleasant, often harsh, consequences (Bent, 1993). Frequently, it is the oppressed who will dispense these consequences, a process that Freire (1970) refers to as horizontal violence.

That nurses meet the criteria of an oppressed group is described extensively in the historically, nursing education has been derived from the dominant medical model; in fact doctors use to directly oversee all training and curriculum content (Morrall, 2006).
Nursing education theory has been almost exclusively informed by a positivist paradigm, which is steeped in logical, reductionistic, and empirialistic methods (Wilson-Thomas, 1995; Morrall, 2006). Theory is an endeavour that attempts to describe the world in which we live by making connection between what things might mean and how they may be related to one another (Scott & Marshall, 2005). Crow and Gotell (2005) add that theory is the process of “constructing informed interpretation of the world in which we live” (p. 39). Given the direction theory can provide, the paradigm it emerges from is of critical importance. Crow and Gotell argue that if any progress is to be made in the area of oppression against women (and the vast majority of nurses are still women) the theory utilized must challenge established meanings and the power relationships that emerge out of them. In order to avoid elitism or exclusive practices, the knowledge derived must remain totally available to those who need it to transform their lives in both the public and private arenas. They also stress that theory must always remain “critically self-reflexive” (p. 39) about any of the meaning and connections that emerge from it.

Theory that arises from a medical model does none of these things; in fact it does the opposite by maintaining the status quo. The focus on medical tasks and technical innovation at the expense of nursing values such as caring and interpersonal relationships reflects the dominant, medical paradigm (Fletcher, 2006). To gain power it is assumed that knowledge of a positivist nature is needed, hence the heavy emphasis on science and technology (Bent, 1993; Fletcher, 2006). This contributes to oppression in nursing, because what is valued by nursing, - the experiences of actual people - is ignored (Wilson-Thomas, 1995). The assumption is that one group of health care providers, traditionally male doctors, are more important than all other health care professionals,
who remain mostly female. Traditional medical model approaches justify and rationalize knowledge that serves to privilege masculine perspectives at the expense of feminine experiences, contributing to oppression (Crow & Gotell, 2005), helping to sustain the biases inherent in gender issues imbedded in the health care system. The health care system far from being gender neutral, is "strongly patriarchal" (p. 53), divvying up jobs along gender lines in hierarchical fashion that privileges male activity over female activity (Fletcher, 2006). The organizations then recruit women who are willing to follow orders in a passive fashion, and put in place controls to ensure compliance (Fletcher, 2006). Nurses, symptomatic of those who are oppressed, exert the controls over each other, inflicting horizontal violence regularly by undermining each other, sabotaging, bickering, scapegoating, and failing to support each other (Bent, 1993; Fletcher 2006). The reliance on a patriarchal medical model thus sustains the power imbalance leading to a climate of shame and blame which suppresses the acknowledgement and discussion of mistakes.

Additionally, knowledge obtained in this oppressive and controlling fashion is limited in its application to the lived experiences of students and clients, failing to take into consideration what their experiences mean to them, thus sustaining the "androcentric ideology of domination and power" (Wilson-Thomas, 1995, p. 571). Nursing process, the traditional mainstay of all psychiatric nursing curriculums, which is based on nursing theory, requires nurses to anticipate human responses in an effort to control them, thus promoting dependence on those providing care rather than promoting client autonomy. This in turn creates a dichotomy between nursing values of holism and reductionistic approaches that fail to acknowledge the mind-body connection and potential
environmental and cultural influences (Wilson-Thomas, 1995), further sustaining the power imbalance. Such traditional scientific approaches are "dissatisfying and limiting for practitioners' creativity and autonomy" (p. 571) and preclude practicing in a holistic manner (Wilson-Thomas, 1995). Nagle and Mitchell (1991) argue the traditional approach to nursing practice is not only oppressive, but is actually unethical.

That psychiatric nursing students also can be described as an oppressed group takes no great leap of imagination. Not only are they in the nursing profession, they are studying psychiatry, a specialty undervalued by those involved in "real" nursing and medicine (Morall, 2006). Add to this their non-expert status and the lack of acknowledgement of the experiences they bring to the classroom, and it is no surprise they feel powerless and oppressed. Psychiatric nursing instructors and leaders, individuals that come from this oppressive environment themselves, then bring to the education process the same internalized oppressive ideology, which in true oppressed fashion, they then unconsciously inflict on their students (Bent, 1993). The individual and their advancement is valued over a team approach (Morin, 1998). Compliance is promoted, with just enough incentive to placate, thus supporting the natural order and stifling questioning of the status quo (Bent, 1993; Morin, 1998). The teacher is the person with knowledge and power, the student a passive repository of the teacher's expertise (Morin, 1998).

The student quotes noted earlier in this discussion reflect this type of oppressive behaviour. The students, having internalized the dominant agenda, often go on to engage in horizontal violence against their clients (Fulton, 1997). The field of psychiatry is saturated with coercive practices providing ample opportunity for caregivers to abuse
their power (Fulton, 1997). Morrall (2006) goes so far as to argue that even the therapeutic relationship and use of empathy, "whilst appearing magnanimous and 'person centered', functions as a virulent instrument of control" (p. 63).

In such a culture where horizontal violence runs rampant, mistakes will continue to be underreported and learning opportunities will be missed. Kroll et al. (2008), in their study of junior doctors in the National Health Service of the UK, identified three issues that prevent health care practitioners from being able to utilize mistakes as a learning tool: the culture of shame and blame that inhibits the admission of errors; failure to pay attention to mistakes that almost happened but were corrected before execution; and inadequate reflection on the part of individual practitioners who are reluctant to admit their own flaws. In such an atmosphere, the dialogue necessary to promote beneficial learning and enhance responsibility and accountability fails to take place (Kroll et al., 2008). Kroll et al. (2008) found that in a culture of shame and blame, practitioners are inclined to report the errors of subordinates but not their own or those of their peers, and definitely not their superiors; they tend to express concern that admitting errors, especially in a climate of competition, would result in career suicide and believe reporting errors would result in bullying and scapegoating being directed at them. As a result, Kroll et al. found that the reporting of errors was highly selective. They also found that important learning moments were missed because the junior doctors failed to get help. Kroll et al. state that the "conspiracy of tolerance" or the "Berlin Wall" around the issue of making mistakes must be dismantled before practitioners can engage in the discussions that are necessary in order to learn from mistakes. They also stress that those discussions can only take place in a supportive and constructive learning environment.
Kroll et al. emphasized that "while a culture of blame prevails, doctors will not report errors" (p. 988). Given that nurses are considered doctors’ subordinates, it is a fairly safe assumption that Kroll et al.’s findings would also apply to them.

Crigger (2005) offers more insight into the reason for the failure of nursing instructors to encourage the exploration of mistakes. She states that nurses practice in a "culturally based expectation of perfection" (p. 11). She compares two models of mistake making: the Perfectibility Model and the Faulty Systems Model. If operating from the Perfectibility Model, which she argues most nurses, and nursing instructors, currently do, the cultural consensus on mistakes is that health care delivery is supposed to be error free and that practice can be "so effective that it eliminates the possibility of mistakes" (Crigger, 2005, p. 12). If a mistake does occur, then it is presumed to be the fault of individual who is deemed to be inadequately prepared or unmotivated (Crigger, 2005), who then experiences the full brunt of that error in isolation, subject to the controlling influences of horizontal violence. Crigger argues that such an atmosphere leads to "secrecy, limited disclosure, avoidance and distancing" (p. 12) in order to avoid the dissonance and consequences that disclosure would invoke in such a perfectionist culture. In such a model, Crigger argues, the expectation of perfection leads those who do make mistakes to experience severe moral discomfort and untenable levels of self-blame and cognitive dissonance. Crigger states, consistent with the findings of Kroll et al. (2008), that in such a culture, instead of experiencing the benefits that can arise from making a mistake, such as dealing with it in a responsible manner, finding solutions, and engaging support (e.g. managing the mistakes), the individual experiences only the negative consequences and engages in denial, self justification and dissociation.
Crisiger (2005) describes the Faulty Model System as a way out of this conundrum. She states the Faulty Model System recognizes mistakes as mutiplicite, a part of being human, arising within the context of the circumstances that the individual may be dealing with. Crigger, along with While (2003), cites air traffic control as a good example of an industry that recognizes that mistakes can happen, and instead of blaming individuals, puts in place safety systems that prevent them. Crigger and Meek (2007) suggests such an approach will lead to more effective ways to resolve mistakes, reducing dissonance, and allow growth to occur.

It is my contention that by exploring the meaning of mistakes and the implications for psychiatric nursing education practice that may arise out of this exploration, that psychiatric nursing curriculum may be able to move away from the Perfectibility Model towards the Faulty Model of mistake-making. This is consistent with Dewar & Walker's (1999) finding in their Illuminative Evaluation of work-based learning that in an environment where the process of learning is the main priority, nursing students were not scared to describe what didn't work, viewing it as a sign of a mature professional as opposed to someone who is ill prepared or unmotivated, or as Salmon and Keneni (2004) describe, weak. An environment where the process of learning is valued as much as the outcome encourages and supports the reflection needed to help students identify what may be questionable or problematic (Dewar & Walker, 1999), allowing them to find solutions to problems rather than avoiding admission that an error in cognition or activity has occurred.

To assist in overcoming the "conspiracy of silence" and culture of shame and blame so that mistake making can be fully realized as a learning opportunity, Berman
(2006) outlines a protocol for managing mistakes in professional clinical settings. First, acknowledge the error. Next, without delay, apologize (both student and instructor) to the client, regardless of whether the error will or will not cause harm to the client. Third, manage the error and do everything possible to mitigate its consequences. Fourth, engage in critical reflection with the instructor or supervisor. Fifth, bring the mistake forward to the larger group so all can benefit from the learning. Lastly, determine what changes need to be made to avoid the same mistake occurring again. Berman states that the first three steps help to manage the impact of the error and the last three ensure the most learning possible is obtained from the experience.

Berman (2006), along with Ziv et al. (2005), and Kroll et al. (2008), all stress that such learning can only take place in an atmosphere of trust and transparency that is sensitive to the learner’s experience, where the teachers can model their own fallibility and offer constructive feedback that allows students to sit with their cognitive dissonance in a manner that promotes reflection and not defensiveness. The ability to "sit with" the feelings evoked by cognitive dissonance is critical in turning mistakes from something to be shunned into the powerful and efficient learning experiences they are meant to be (Ziv et al., 2005). Gladwell (2008) adds that since it is often a combination of errors that lead to actual problems it is imperative to set up an environment that leads to early recognition of errors, and this requires overcoming "our cultural legacy" (p. 183) that inhibits admission of mistakes.

Yet, it takes more than addressing the cultural environment to get students to sit with the cognitive dissonance necessary for learning from mistakes. If the goal is to have more students be accountable for their mistakes and engage in not only correcting them,
but learning from them, they need assistance to overcome their natural inclination to self justify. Tavris and Aronson (2007) define self justification as the unconscious process "which purrs along automatically…protecting us from the dissonant realization that we did anything wrong" (p. 222). Its purpose is to decrease the level of dissonance felt by "preserving our beliefs, confidence, decisions, self esteem, and well-being” (p. 222).

Tavris and Aronson argue that since most people are inclined to decrease dissonance in a manner that puts them in the most positive light, that "we can't wait around for people to have moral conversions…that will cause them to sit up straight, admit error and do the right thing" (p. 223). The authors also argue that dissonance can be used to create what they call a "virtuous circle" (p. 28) – that helps people see the advantages of carrying out beneficial acts which in turn leads to more good deeds.

Nel Noddings (2002), in her book *Educating Moral People*, provides insight into how to overcome self-justification, asking the question "How we might produce better people" (p. 1)? Noddings argues that those who act morally don't rely on abstract principles or only on reason, but instead are motivated by their own internal moral compass and through their relationships with others. Noddings, like Gillespie (2002), asserts that reason levelled without caring leads to cruelty and coercion. She argues it takes more than just critical thinking to develop morality, and that in order to care, one must be cared for. Noddings states, “How good I can be depends, in substantial part, on how you treat me” (2002, p. 2). She proposes an ethic of caring which goes beyond care theory and its emphasis on critical thinking and a caring relationship, by placing emphasis on caring as a virtue. Noddings questions whether virtues can be taught directly
and suggests instead that a safe environment needs to be created to allow the desired virtues to emerge.

To admit mistakes requires virtue. The main virtues that need to be present in order to engage in learning from mistakes are honesty, humility, transparency and trust (Berman, 2006; Crigger, 2004; Tschudin, 1998, Ziv et al. 2005). Just promoting virtues through character education, which relies on a strong community or culture, and consensus, is not enough. Nodding states, "to rely on community consensus is to lean on a (Berlin) wall made of flimsy material and colourful paint" (p.23), and failure to look past such consensus could lead to marginalizing those with diverse or creative perspectives, thus promoting horizontal violence. As the health literature demonstrates, the culture of shame and bullying that promotes power driven loyalty over honesty is actually detrimental to ethical practice. Noddings suggests that what is important is not consistency, but rather being sensitive to the lived experience of students, and providing support and encouragement. She states that it is important to “concentrate on establishing the conditions most likely to support moral life” (p. 9). She also stresses that regardless of the conditions established, there is no guarantee students will behave morally as no one can ever be fully responsible for another's acts. It does, however, behoove educators to do what they can to create a culture conducive to acting virtuously, which places greater emphasis on critical self-reflection (Noddings, 2002).

A moral education has several key components: modeling; reflection; and dialogue (Noddings, 2002). Modeling involves not only demonstrating what it means to care, but also, in terms of promoting honesty, humility, trust and transparency vis a vis mistakes, sharing ones own stories of fallibility. Consistent with the learning theory
previously presented, Noddings (2002) stresses reflection as critical – not only from students, but also from their instructors who need to constantly examine how their behaviour impacts the learning process. Lastly, dialogue is described by Noddings as "the most fundamental component of the care model" (p. 16). She advocates for the kind of dialogue Freire (1970) suggests being used to confront horizontal violence – open-ended, inconclusive, egalitarian and immersed in the lived experience of participants, never neglecting their humanity. The central question in such a dialogue is always “What are you going through" (p. 17)? Engaging in such a dialogue sets up a safe environment that promotes the kind of disclosure necessary to allow the participant to effectively respond to and manage the problems, such as facing mistakes. Such dialogue is uncompetitive, the goal being to explore rather than justify. Noddings points out that the concern may never actually be solved, but the purpose is to establish relationships in which "natural caring will guide future discussion and protect participants from inflicting and suffering pain" (p. 18) – a sentiment most apropos for countering a culture of shame, blame and bullying. Feedback provided in such a dialogue is delivered without shame or guilt, and students will pay more attention to this feedback if it is given by instructors they trust and who care about them (Noddings, 2002).

This then begs the question, what will it take to transform psychiatric nursing culture from one that discourages the exploration of mistakes as a learning opportunity to one that embraces it as a virtue? Nursing literature specific to the topic of emancipatory pedagogy emphasizes two approaches to engage psychiatric nursing students in the critical dialogue which is necessary if mistakes are to be used as a learning experience: fostering the student-instructor relationship; and engaging in a narrative pedagogy.
Gilligan (1982), consistent with Noddings' Ethic of Caring, states that it is through relationships that individuals describe themselves, therefore, fostering connection is of paramount importance. Gillespie (2002) asserts that it is only through a supportive and caring relationship with an instructor that students develop confidence, become motivated, and learn to their full capacity. Schreiber & Banister (2002) suggest that putting the focus back on teaching is key and recommend, “unpacking and questioning the routine behaviours that may contribute to student oppression” (p. 44). Instructors need to be nurturing, respectful, available, willing to engage in dialogue, prepared to share some aspects of themselves, and recognize that students have lives and obligations beyond the practice setting (Gillespie, 2002; Schreiber & Banister, 2002). Behaviours and attitudes of this nature provide an atmosphere of trust and compassion, fostering communication and learning (Gillespie, 2002; Schreiber & Banister, 2002). Such approaches are egalitarian and freeing for all involved (Gillespie, 2002).

Another possible approach to change the psychiatric nursing culture is to utilize narrative pedagogy. As described by Diekelmann (2005), narrative pedagogy can encourage teachers and students to challenge all ideas presented, particularly those considered sacrosanct. Narrative pedagogies promote an atmosphere that fosters security, equality and respect (Ironside, 2003). Critical dialogue and reflection is fostered; there is less focus on content, more emphasis placed on questioning meaning and implications; the end is not the goal, but rather the process of getting there; multiple perspectives are scrutinized; the teacher is viewed as knowledgeable only about certain topics and freely admits ignorance about others; all assumptions and truths are challenged; the teacher and student explore together to find solutions; teachers are directive only to clarify what
students must know to decrease confusion; listening is emphasized; and autonomy and responsibility are promoted (Diekelmann, 2004, 2005; Ironside, 2003). The ultimate goal is to mentor psychiatric nurses who can solve problems, find information and resources, seek help where appropriate and critically evaluate multiple viewpoints (Diekelmann, 2005). All of these approaches require teachers and students to take risks, to become uncomfortable, unsure, and uneasy – to endure cognitive dissonance. As Crow (2003) states, teachers and students alike must learn to "reside at the border... a space between the past and the future that is uncomfortable but that is an essential characteristic of innovative leaders" (p. 6). It is only in this place that psychiatric nursing students and their teachers can break free of the dualistic, objectifying and spirit numbing practices that characterize a pedagogy of oppression and embrace a pedagogy of emancipation which encourages the honesty, humility, transparency and trust needed to explore the experiences related to making mistakes.

While there is extensive research in the nursing literature on the nature of instructor-student relationships that promote learning (Diekelmann, 2005; Gillespie, 2002; Salmon & Keneni, 2004), making mistakes and its impact on learning is described only very briefly. Most research into the phenomenon of making mistakes in nursing relates to making medication errors (Davis & Cohen, 1987; Karch & Karch, 2003; Lippincott, Williams & Wilkins, 1994). Davis and Cohen's (1987) focus is on how nurses must avoid certain types of medication errors, and they describe procedures, policies and specific tactics (single verses multiple tablet delivery systems, misleading drug names and designation, unusual drug orders) that can be implemented to reduce errors. Karch and Karch (2003) identify the importance of staff and patient education as the key to
preventing mistakes that can result from unidentified allergic reactions when administering medication. The Lippincott et al. (1994) research addresses the importance of patient teaching and education as methods for reducing common medication errors when using inhalers, attributing the cause of errors in this case, to lack of knowledge of how to administer medication properly. Common to all three studies is the stress placed on avoiding mistakes – what Crigger (2005) describes as a perfectibility model, as opposed to the recognition that due to the human element involved, mistakes will happen regardless of any policies or procedures in place –and ignores what Crigger calls a faulty systems focus.

Another study addresses the fixation students had on marks and the need to challenge instructors to give better grades, "even when they know they are wrong" (Diekelmann, 1992, p. 78), indicative of an unwillingness to accept gaps or misconceptions in their knowledge base. Tabak and Reches (1996), in their study of how nursing ethics are applied, describe how nursing students, midwives and nurses report mistakes. All surveyed agree reporting mistakes is the ethical thing to do, however, 68% percent of nurses and midwives surveyed failed to report mistakes, and an even more astoundingly, 80% of nursing students stated they didn't. The authors wondered what might be the cause of these finding, but didn't provide any actual illumination. Luk, Ng, Ko, and Ung (2008) describe how nurses fail to inform the patients and their relative of medication errors even if they do report the mistake to their superiors, raising ethical concerns. Needleman (2007) asserts in his study of nurse's performance that the key to dealing with mistakes is to tighten standards scientifically, again failing to acknowledge that humans are going to err regardless of policies or procedures in place. Only one study
found (Malinski, 2003) suggests that mistakes can be an opportunity to learn rather than just a problem to be corrected with protocols, but her focus is on the research process and not on student education. In another study, Lazarus (2006) explores consumer perceptions of nursing mistakes, and compares them to those of nurse educators and administrators. None of these studies touch on mistakes as a learning opportunity. Most of the studies described focus only on how to prevent mistakes, addressing neither how to learn to manage mistakes when they occur, nor acknowledging the cultural influences that ensure that mistakes continue to go underreported.

Only one study found described the experience nurses had making mistakes. Crigger and Meeks (2007) in their grounded theory study address mistakes in a broad sense and seek to understand the nurse's perception of mistakes and what they experience in making them. Their focus was on how nurses reconcile making mistakes after the event in the hopes of advancing a theory of mistake making. They stressed the need for avoiding "the culture of shame and blame" (p. 177) which leads to mistakes being “grossly underreported" (p. 180). They suggest instead, engaging in a dialogue that helps nurses reconcile the cognitive dissonance they experience when making a mistake in healthy ways that promote growth and development for the nurse, rather than evoking denial, disbelief, rationalization and blame.

All the studies noted above refer to general nurses and nursing students. Only two studies in the literature refer to psychiatric nurses and mistakes (Stevenson & Jackson, 2000; Arvidsson, Lofgren, & Fridlund, 2000). Both articles explore clinical supervision issues. Stevenson and Jackson utilized a grounded theory research approach and one participant refers to mistakes as something to be punished for. Arvidsson et al.'s
phenomenological study describes mistakes as the ability of psychiatric nurses to "dare to expose their shortcomings" (p. 183) in a supportive supervisory situation. Beyond this there was no further discussion in either article. None of the literature found investigated the broader meaning of experiences of nursing instructors or students with making mistakes (e.g. the essence).

Given the gaps in the literature, more phenomenological research is required in order for psychiatric nursing instructors to understand their experience as it relates to making mistakes, and how it impacts their students' learning. Only by gaining an understanding of the meaning that making mistakes holds, can instructors begin the process of transforming the learning environment to support exploration of how making mistakes influences their students' learning experiences. Such exploration would not only mitigate any potentially unpleasant consequences that making mistakes may have for the students and the psychiatric nursing clients they care for, but also foster the acquisition of good judgment.
Chapter Three

An ancient Chinese story tells of a pottery master who was approached by an individual who requested that he teach him to make bowls from clay. The master presented him with a bowl that one of his own teachers had made, and said: "This is how your bowl should look. Use it as a model, try to copy it over and over again, make a lot of mistakes and corrections, and come back to me after you have attempted to make 10,000 bowls." (Ziv, Ben David, & Ziv, 2005, p. 194).

Research Design

Choice of methodology. Phenomenology is a method of inquiry that investigates phenomena and was developed by Edmund Husserl, a German philosopher, to investigate consciousness in a rigorous manner (Scott & Marshall, 2005). Creswell (2007) states that the goal of phenomenological research is to describe how this consciousness, or phenomena, is meaningful to numerous individuals who experience it. According to Creswell, the focus is on the aspects of the phenomenon all the individuals participating in the study may experience in a similar manner. He further asserts that it is hoped that by describing the experience of several individuals, common themes will be revealed allowing researchers to understand both what and how the phenomenon impacts the participants. Creswell (2007) describes two types of approaches: hermeneutic which interprets “the texts” of life (p. 235) and transcendental which emphasizes minimizing bias, relying on intuition and common constructions for determining meaning. It is this latter variety that was engaged for this study.

A phenomenological approach is well suited to address the question "What are you going through?" which Noddings (2002, p. 17) asserts is central to critical dialogue.
Phenomenological research is language-oriented and responsive to the participant’s life world (Van Manen, 1990). For Van Manen (1990), to engage in pedagogy involves interpreting phenomena in a manner that is relevant to those who experience it. He also asserts that the research process must engage language in a textually reflective fashion that is sensitive and diplomatic. Van Manen argues that phenomenology allows the researcher to move away from that which is objective and divorced from lived experience, and oppressive, toward Geist – “mind, thoughts, consciousness, values, feelings, emotions, actions, and purposes, which find their objectifications in languages, beliefs, arts, and institutions” (p. 3). Consistent with Heidegger (Neilsen, 2007), Van Manen asserts it is through these objectifications that meaning emerges about how humans experience their world.

From a phenomenological perspective, research and writing are inextricable pedagogical undertakings, hence the emphasis on structural, textural and composite descriptions to get to the essence of the phenomena under study (Van Manen, 1990). The goal is to “throw some light on the matter” by engaging “the principle of intentionality” which allows us to delve into the mysteries of what it means to be human and in the world (Van Manen, 1990, p. 5). Van Manen (1990) states that research of this nature, consistent with Nodding’s Ethic of Caring, “is a caring act: we want to know that which is most essential to being” (p. 5). Such an approach is holistic, thoughtful and sensitive - “a caring attunement”, that encourages faculty to “act responsibly and responsively in all our (pedagogical) relations” (Van Manen, 1990, p. 12). Van Manen posits that the rich or thick descriptions that arise from phenomenological research are a “moral force”, that illuminate “what is means to be human” allowing us to become “more fully who we are”
Consistent with critical dialogue as described by Freire (1970), there can be no conclusions – there will always be more to say (Van Manen, 1990).

Phenomenology is thus a fitting approach to investigate the meaning mistake-making holds for psychiatric nursing instructors. Not only does it have the requisite sensitivity needed to overcome oppressive practices, it is also holistic and values, as stated in Chapter Two, what psychiatric nurses hold dear: the experiences of actual people - their health, their environment, sharing and caring, in other words the humanness or "essence of nursing" (Wilson-Thomas, 1995, p. 568). Psychiatric nursing involves contemplating what motivates people to think and behave the way they do, to consider how the context of those thoughts and behaviours arise and impacts the person, to evaluate what the person thinks of the situation and what is actually going on inside their heads. Self reflection of this nature is required in order to be a fully conscious and ethical professional. A methodology that ignores matters subjective in nature would limit inquiry to second order structures – that which is considered factual, generalizable, and fits into existing laws and theories – devoid of dialogue (Lincoln, 1992). Nursing, as an applied discipline that constructs knowledge based on the dominant positivist paradigm, does not want for such inquiries into objective matters, and engaging in more of the same will yield no new insights. By utilizing phenomenology as a methodology, a dialogue about the meaning that mistake making holds will unfold, revealing new possibilities for understanding that reflects the deeper, richer and more complex lived experiences of psychiatric nursing instructors.
Procedure.

Participant selection and sites. The study was conducted through a psychiatric nursing school in a large urban area in Canada where I teach. This allowed access to a ready participant population and efficient use of limited time and resources. The actual settings varied dependent on the wishes of the participants. One interview was done at my home, one interview at a participant’s home, one in my office, two in the participant's offices and one in a room booked on campus. Regardless of the setting, the atmosphere was quiet and private.

Criterion sampling was utilized to determine participant's suitability for the study. Only post probationary faculty (e.g. no longer subject to peer evaluation) were invited to participate to ensure that I was not in a position of power over them. Any gender, age, or other attributes were acceptable for inclusion but all had to be willing to share through an interview, their experiences of making mistakes in their learning process, and be willing to commit the necessary time to the research process. An invitation to participate was placed in the faculty mailboxes of all eligible faculty. I also posted the invitation to participate to the faculty on the school's electronic messaging system. The first six instructors to respond were invited to participate. Initially it was planned for all six to participate in the data collection phase but then to select five randomly for the data analysis phase. This was to cover for potential dropouts. However, since no one dropped out and all had much to contribute, I elected to analyze the data from all six participants. A copy of the study's abstract was provided to each potential participant and they were informed they could have access to the whole research proposal should they wish to see it. All were given the interview questions to be asked ahead of time in case they might
object to any of the questions, and to allow them to consider their responses more thoughtfully if they wished.

*Participant motivation.* The main reason faculty participated in the study was a keen interest in the subject matter. One participant states, “This is an excellent topic; it is a very timely topic”. Another stated, "It’s interesting to think about…if things don’t go well”. A third said, “I never really thought of this a topic before but I think it would be interesting to bring it up, like in a department meeting and just see what people’s views are”. A fourth participant likened the opportunity to discuss a recent mistake in the interview as "kind of like therapy". In addition, one instructor was more than willing to participate because I had been a volunteer subject in her M.Ed project. Two others are embarking on post graduate work and will be putting out calls for participants in the near future, so some reciprocity is at play.
Participant profile. All six participants were white female faculty between the ages of 35 and 55 years. They were the first to respond to the invitation to participate. None had less than 10 years nursing experience in the clinical area, and several had considerably more. Teaching experience varied from between 4 to over 20 years. All have taught in the clinical as well classroom arenas.

Data collection. Consistent with phenomenology as an approach to research, the main source of data collection was in-depth interviews (Creswell, 2007) and the participants were invited to participate in an on-line focus group. They were also invited to add their own questions if they wished, for the purpose facilitating an atmosphere of equality, safety, support and encouragement (Kemmis & McTaggart, 2005). Data was collected in the following ways (see Appendix A for list of Sample Questions):

- Audio taped ½ hour to 1 hour individual interview; and
- On-line focus group, which was available for a five week period at the participants' convenience. Time recommended to participate was an 1 hour, not to exceed 2 hours. This was extended from the original two week period due to the two week Olympic break.

All 6 faculty participated in the individual interview and 5 faculty participated in the on-line discussion. One faculty member opted out of the on-line discussion because of having other priorities during that period of time.

I kept a journal to reflect on my own experiences of the phenomenon including any thoughts or feelings that emerged through the research process. A data collection matrix was used to keep track of the data. All data was dated and labelled for identification and organizational purposes.
**Data analysis.** Consistent with the methods described by Creswell (2007) who in turn acknowledges both Moustakas and the Stevick-Colaizzi-Keen approach to phenomenological analysis (as cited in Creswell, 2007), my analysis involved outlining fully my own experiences with mistake-making and the meaning it holds for me. This included my own experiences of mistake making as a student nurse, psychiatric nurse and psychiatric nursing instructor. I then bracketed-out (epoche) my personal bias, as best as I was able, before continuing with any further analysis. I coded all participants' data in a vertical, then horizontal manner, to determine the significant statements. Given that dialogue and reflection are a pivotal part of phenomenological research, it was important to subject my interpretations to the feedback of others, in order to "lay it open, to place in the open" (Van Manen, 1990, p. 100), to see past my own biases and weaknesses of thought, and rise above any limitations such biases invoke. Given that I am studying in "my own backyard", it was very important to employ several forms of external validation to reduce any potential bias that may creep in to the analysis (Deborah Begoray, personal communication, July 17, 2008). To this end, I engaged a non participating Master’s educated colleague, who did not know the participants in the study, to also code the data to provide inter-coder agreement, achieving a consistency of 85%. Meanings were formulated from the significant statements and consistent with Colaizzi (as cited in Creswell, 2007), I developed a table of the seven themes derived from the 145 significant statements. Next, I wrote a textual description of the meaning that emerged from the 7 themes. I also included a structural description of where and how the participants experienced the 7 themes that emerged. A thick description of the essence – a composite description –was derived to describe participants' common experiences, and how they
experienced them. I created a computer template for organizing all the different parts of the analysis. I next evaluated the validity of my results by employing member checking and triangulation, in addition to addressing my own bias, the inter-coding reliability and writing a thick description already described. All 6 participants reviewed their portion of the data and all agreed that my interpretation reflected their intent.
Chapter Four

A life spent making mistakes is not only more honourable, but more useful than a life spent doing nothing.

- George Bernard Shaw

The Findings - The Meaning of Mistakes

Epoche. Being a flawed human with a penchant for suffering from perfectionist traits, which has unfortunately led to much judgment of both myself and others, I have struggled over my lifetime to learn to accept the errors of my ways. Twenty years of practicing psychiatric nursing and seven years of teaching has given me the opportunity to make many mistakes. I have made medication errors – I once gave the frailest client on the unit someone else’s medication because I failed to do all the necessary checks. I have made procedural errors - once I took out someone’s stitches prematurely when the chain of communication broke down. In both cases, the physician was notified, the necessary follow up occurred, and the client was informed and unharmed. I have made multiple therapeutic communication blunders and haven’t always practiced a non-judgmental, detached and respectful stance. I have made assumptions without all the facts and overreacted in some situations as a result. In my teaching role I have often made mistakes due to lack of experience – in my first semester of teaching in a hospital setting, I taught 16 students the wrong way to landmark intramuscular injections, and can only hope others picked this up and corrected it. I have suffered from the mistaken belief that I need to know it all and put my foot in my mouth many times. I have weighed into situations with students too quickly, giving responses I later regretted.
I have also experienced the full gamete of feelings that have resulted from my errors – stupidity, embarrassment, horror, guilt, doubt, shame, anguish, anger, anxiety, worry, concern, to name a few. Fortunately, I have also been able to, either through time, reflection, or experience, generally move forward, so that rather than repeating my mistakes, I can go on to make new ones. Maybe one day I will be able to demonstrate, in the words of a very wise woman I had the privilege to know, superior intelligence, by learning from other people's mistakes, but I am not going to hold my breath.

As the students quoted in Chapter 2 expressed, I frequently experienced less than a nurturing and supportive environment in my own nursing education, which bothers me to this day. When I started teaching, my motto was to treat my students how I wished I had been treated, and when I discovered, from listening to my student's and other faculty's accounts, and reading survey feedback, that they often weren't, it made me angry. Getting angry is often my response to feeling powerless to make change. It is often my response when I err. I have had a tendency to react, often with out considered thought, in the face of adversity. I have also learned, mostly the hard way and usually in response to some challenge or error, to monitor my thoughts and reactions, in order to practice more detachment. As I listened to my participants' stories, I kept a journal of my reactions, noting the situations and statements that evoked them. I also made note of the times I was commiserating, or relating the content expressed to my own experiences. If the data evoked an emotional response while I was analysing it, be it pleasant or unpleasant, I would take a break, reflect on what was causing my response, and then later revisit the data from a more detached standpoint, having attempted to bracket out my
biases. This helped to prevent me imposing interpretations on the data that served my own agenda, at the risk of losing the participant's voice.

**Themes generated.** Seven themes emerged from the analysis of the 145 significant statements produced by the participants who are referred to in this analysis by their pseudo-names. The experiences described arose in multiple settings (including one overseas), circumstances and periods of time. Two participants, AS and FF, who both currently teach in classroom settings, when recounting a mistake they made, chose events that occurred very early in their careers as practicing nurses in a hospital setting in acute surgical areas. AS described how, as a brand new nurse, she failed to observe that a hemivac drain valve was closed over night and that she could have killed her patient. Fortunately the client was all right, and because of this, the more experienced nurse told AS that they would keep this a secret, which she did and she regrets to this day. FF chose to describe a mistake she made, also as a new graduate, mixing up the terms systolic and diastolic for a blood pressure reading, which led her to give an anti-hypertensive medication when the doctor's order indicated it should be held. Again, the client was all right and in this case, all the procedures for reporting an error were followed.

For EE, who currently teaches in a clinical setting, the focus was on a mistake made 10 to 15 years ago in the acute psychiatric clinical area as an experienced practitioner. She misread the label on a bottle of medication and gave an adolescent client the wrong medication. After some internal debate as to whether to wake up the on call psychiatrist or wait until the morning, given the client was apparently unharmed, she did make the call, filled in all the necessary forms and carried on with what she stated was a very, very long night.
BJ, who teaches both in the classroom and clinical settings, describes a mistake that occurred 5 years into her teaching career in a classroom setting. It was a class for practicing therapeutic techniques that utilized actors as simulated clients. At the very end of the last class of the last semester, the actor involved announced, to both the student role playing the nurse, and the rest of the class who were observing, that after the interaction she felt that if she were an actual client, she would likely commit suicide. BJ describes her mistake as a failure to bring closure to the scenario, leaving the students feeling that they had just killed a person. It left her feeling intimidated and shocked. She joked that later she bumped into one of those students who remarked "I was in the class where we basically killed the person." DB spoke about when she was a new instructor in a chronic psychiatric setting how she failed to appreciate the need to not overwhelm students early in the program with expectations too high for their level of experience. CH, who teaches in both classroom and clinical settings, chose to speak to a mistake which occurred during her 4th year of teaching, the repercussions of which were unfolding as the interview occurred and are still in process as I write. She described letting some unprofessional student behaviour go on too long before addressing it, so that when she finally did address it, she was more reactive than would have been ideal, leading to a protracted power struggle.

The mistakes described above reflect the full range of mistakes described in the literature. AS, FF, and EE's errors were mistakes of omission or skill based slips resulting in failure to carry out the act. FF and EE's were acts of commission; they carried out the wrong acts. Both of these were also slips. BJ's was both an act of omission as she failed to debrief her students, and an act of commission or misuse due poor judgment, what
was intended is not what occurred. CH's was also an act of omission as she failed to address a problem she had identified, which was then compounded into an act of misuse resulting from a failure to plan. DB’s was an act of misuse as the best of her intentions resulted in the students being overwhelmed rather than motivated. All experienced the dissonance that results from making mistakes and all subscribed to having learnt an incredible amount from their errors.

**Theme 1: Mistakes lead to multiple negative feeling states.** Whenever a mistake enters conscious awareness, cognitive dissonance results, due to the discrepancy between what is expected and what actually occurs, causing a range of feelings from slight discomfort to total devastation. The six participants were no exception, as all related very strong emotional reactions when they made mistakes. One participant described being "intimidated", and feeling "overwhelmed…like this bomb went off". Another had "that whole sense of devastation…I mean I was upset!" A third said, "I just felt dreadful…and …stupid…and embarrassed". A fourth stated she felt, "Surprised …I took it personally, beating my self up about it and then feeling guilty". Another recounted feeling "really sad…a little bit resentful…uncomfortable". Physical reactions often accompanied the feelings. One participant described "sweating bullets", and another stated, “I just about died… my heart just jumped into my throat". It was clear that none were unaffected, either emotionally or physically, by the mistakes they described. In fact, they were quite distressed.

Doubt was an emotion common to most of the participants. One recounted how she "felt like I failed…felt uncomfortable and the whole thing just felt crappy." Another described how the mistake caused her to seriously consider giving up nursing because it
caused her to doubt her abilities to practice safely. A third stated, "I thought maybe I am not a very good instructor and started to doubt myself…maybe I am not cut out for this."

Fear was also a frequently cited reaction. As one participant explained, "It's that 'holy crap'…it’s a looong night, a reeeally long night, probably one of the looongest nights, um, just making sure that the youth was going to be ok." Another stated, "I thought Oh My God, I hope they are not going to die." AS remarked, "I know it definitely scared the pants off me, that I kind of didn't go into surgical after that. I backed away and so everything became a little more scary as a new nurse."

As the participants recounted their mistakes it was evident that the mistakes made were still having an effect on them to this day. Five participants described mistakes that had occurred many years ago, two of them mistakes that happened at the very beginning of their careers. BJ recalled, "That will probably always haunt me a little". As FF spoke about being a new grad and making a procedural error, she commented she could remember the mistake clearly to this day. AS said:

There is a big one I will never forget as long as I live, when I was a brand new nurse…it haunts me…in fact I've had dreams where I wake up in the middle of the night and think, Oh My God, I need to quit nursing because I could have killed him…I'm still sick about it.

Making mistakes clearly invoked intense, and often lasting, feeling states for the participants.

**Theme 2: Mistakes are an opportunity to learn and grow, or not.** All the participants spoke of mistakes as an opportunity for growth and development. Mistakes were also described as changing how one does things by inspiring critical thinking, the
application of theory, and promoting problem solving. The participants suggested that mistakes can increase awareness. The key to whether mistakes are embraced as a learning opportunity was repeatedly attributed to attitude, particularly a willingness to be honest, humble and prepared to critically self reflect. What came through loudly and clearly is that all six participants view making mistakes, both for themselves and their students, as an opportunity to learn and grow, if the person is willing to admit their errors. AS stated, "I think it's a huge learning experience…mistakes have driven a lot of what I've done." BJ said she "realized it did make a change for me …much more taking the drivers seat …being a lot more clearer." FF commented that she responds to mistakes by "gaining more knowledge, you know, making sure I know what's right…and being more prepared." She also added, "I think, Oh My God, if you do things right, what would you learn out of it?" CH said, "Well I always think that people learn from their mistakes very, very much because I learn from my mistakes."

The participants described how problem solving can be enhanced when mistakes occur. CH stated, "I truly believe you learn better or more from the things that go off course, and you have to react, and you have to critically think, and you have to apply theory and you have to problem solve, and then your priorities change." FF commented:

It’s by making mistakes we learn all the strategies and know how to do something, you learn, we truly learn how to do something right and be able to problem solve around ways of making it correct, so I think mistakes are an important thing.

The participants also stressed that whether an individual learns from their mistakes or not is very much dependent on their attitude. They described being
accountable, honest, willing to face the consequence and risk discomfort as needed in order to learn from mistakes. CH described the impact of making mistakes on student learning thus:

If they owned up to their mistake then you just have to kind of always go back to what learning has happened because of this mistake, and …they probably will never do it again…because they've had such a good, great learning curve.

EE expressed that some will embrace mistake making and learn, while others may not. She stated that it's important to consider:

How do you react to them? What's the process? Do you follow process? Don't you follow process? Do you air it out? Don't you air it out? Do you deal with it? Don't you deal with it? Do you learn from it?

BJ said it required "not being cavalier about mistakes…being able to be prepared…a good thinker and using common sense and having your knowledge up to snuff, so you are not just stepping into, ah, doo, doo all the time." EE added, "If you have a student who makes a med error and they are kind of flippant and nonchalant about it, to me then, you gotta put a bit of a squeeze on them" in order for them to learn, as opposed to a student who "is devastated…then it's…how do we work with this, what do we need to do and how can this be a positive learning experience from both ends". CH remarked:

If they are sincerely regretful and remorseful…if they truly feel like they've died a thousand deaths…then you think, well, they're learning from this but the ones that kind of go, 'oh, yeah, really?, yeah ok', …they are the ones I want to talk about it more.
The participants described numerous other reasons for not learning from mistakes. Several participants emphasized that dissonance and a capacity to self reflect are required in order to be able to learn from mistakes. CH expressed, "the emotions kind of add to your learning, as long as you can put it into perspective." BJ stated:

The part I like about mistakes is it should make you uncomfortable. If it doesn't make you uncomfortable I think then something else is going on in terms of kind of your attitude of what your goals are, your values are, what you are striving for. AS described how her mistakes made her have "to reflect on what happened". EE added, making a mistake requires "a lot of that sort of self reflection of what happened here, how could I have done (this)...I still went step by step trying to figure out how that mistake happened." DB remarked that it requires considering, "ok, so what are some other ways of looking at it...why did it happen?" BJ commented, “It draws your attention to things…lets you know your blind spots" and can:

Open (one) to the reflection about… how to avoid it next time…unpack it a little to look at what's there…if you take that kind of approach…I think it can be really useful. …If that self reflection piece …is missing it would make me sometimes question what really are your underlying values, what is at the foundation of what you are aiming for?

Only by being able to endure the dissonance and consider the event by self-reflecting critically can, as DB asserted, "professional growth and understanding" evolve.

**Theme 3: Mistakes are inevitable and human; admitting them is "right out there"**. Every participant described mistakes as a part of the human condition and completely unavoidable. The participants agreed that the only way to never make a
mistake is to never do anything. In response to the question about how they viewed those who admit mistakes, they all held such individuals in high esteem and viewed them as good role models, particularly for showcasing the attributes of honesty and humility, as well as how to take risks. BJ remarked:

Mistakes…we try to avoid them, but they are a part of the process of being human. …I just see it as a natural part of being a human critter. …You're not going to make mistakes if you don't do anything.

DB said, "I perceive them as they're inevitable, they are going to happen…I expect them to happen." AS stated, "I think mistakes are a necessary part of what we do. I mean, I think they are a necessary part of what anybody does, because we are human."

Those who admit mistakes were described in a variety of ways. DB described people who can admit their mistakes as having "honesty, integrity, trust, …altruistic, putting the needs of others ahead of themselves,… professional, accountable, responsible, taking their role and their profession…seriously." She also stated that s/he is "someone who is extremely conscientious…who also has good strong morals, and values and ethics. I think above all integrity and credibility." BJ said someone who admits errors is able to take "that kind of ownership, accountability that always makes a big difference… and speaks of a certain, I don't know, authenticity…honesty. …They are not so heavily defended that they can't speak of their foibles." FF believed people who acknowledge mistakes "have a very high work ethic" and she "hold(s) them in high regard. …I can respect someone who can admit to a mistake so it is a positive attribute…honorable…honest, someone who has integrity, someone who has a strong sense of character." CH stated that those who can be honest enough to admit mistakes "are really accountable for
their practice, they're motivated to learn. …It’s a character trait…and they have to be willing to take the repercussions”. EE remarked, "Admitting their mistakes is right out there. To me it goes back to that whole sense of what do you do with it?” Clearly, being able to admit mistakes is viewed as a strength of character and held in high esteem.

**Theme 4: The context of the mistakes is really important.** While mistakes are viewed as an inevitable part of the learning process, the context in which they occur was also viewed as important. The participants described the need to consider whether the mistakes occur due to a lack of preparation, unwillingness to tolerate the dissonance needed to learn and to take risks, a lack of talent and ability, or a lack of confidence. They agreed that one or two mistakes in a particular area are nothing to be concerned about, as long as the needed learning takes place, but that a pattern of similar errors is cause for concern.

CH indicated mistakes often occur when a "lack of confidence and lack of competence and capability" is present. FF states that it could be a "lack of knowledge…it could be someone who just doesn't care and who is lazy." She added, mistakes might occur because a person is "overwhelmed or highly anxious at some time so they are making mistakes for that reason, so I don't really cluster making mistakes due to one reason." FF also stated:

The problem lies when it’s a repeated mistake, and I don't mean repeated once, but you know what I mean, someone who just doesn't have the knowledge base, isn't prepared, …and its an attitudinal thing and not just a cognitive thing. …Then you know maybe they really can't do the program; maybe its to difficult or maybe it is not the right program for them.
AS remarked it could be due to "carelessness, being tired, not caring as much as you
should, just not paying attention, not having the knowledge and skills you should." DB
attributed mistakes occurring due to people being:

Risk takers. Sometimes they're quick, fast thinkers, fast on they're feet, go, go, go,
highly energetic…extremely conscientious to the point they are overly
conscientious when they make errors. Also sometimes people have difficulty with
problem solving, critical thinking…don't look at the big picture.

They, like J.F. Kennedy (Tavris & Aronson, 2007), expressed that what is done
about the mistakes is the critical issue, not so much the mistake itself. EE stated, “the
mistake itself is a mistake” and asserted that it is a question of "how that mistake was
managed" that is paramount. She added it is important to consider if it is an isolated error
or "if it’s a …a mistake that keeps coming over and over, then it would go back to what
have you done with it? Like you haven't learnt anything." DB said "it's trust, now what
are you going to do about it? …You need to come back the next day, learn from it." AS
expressed "it can change your thinking around what are you going to do about that to
actually rectify …a mistake?" For BJ it is important to carry mistakes forward. "If you
see patterns… repeated, of not…learning…from mistakes, of not carrying it forward,
having the sort of…same pattern of mistake" the person's values and goals need to be
questioned. CH stated that it is important:

To remember that they're (the students) going into a profession, and that
professions have a certain integrity,… values, and standards for practice and code
of ethics. …You need to show you are competent. …It is not the kind of
profession [where] you're dishonest and you start to cover up [your] mistakes.
BJ remarked "the context might be a little bit different, … but generally… feel…like overall,… that generally you're pretty competent and developing some skills, and so this one was a mistake, so get back on the horse and try it again." What was important to all the participants was how mistakes are dealt with and resolved, not that the mistake took place.

**Theme 5: To learn from mistakes requires a safe environment.** The participants stressed that if students do not trust their teachers, feel safe and supported in their learning environment, they will not feel free to take the necessary risks that will allow learning to take place. Role modeling both how to treat a person who has made a mistake, as well as how to handle mistakes, was described as pivotal in creating safety to learn. Additionally, sensitivity to the learners’ needs and past experience so as not to overwhelm or discourage them, was discussed as necessary to ensure a safe learning environment.

**Supportive environment.** In order to be able to learn from mistakes the participants all stressed the need to create a safe and supportive learning environment that is respectful and validating. DB stated that it is necessary to have "a culture in the environment of respect…but also a sense [of] trust in the relationship with people…not having a sense of competition, but… recognizing and valuing the skills…being loyal. …Just some recognition would be safe." DB also asserted that "the other thing…is to use humour…feeling that you don't have to be perfect. …You need a real supportive team." She stressed that "you also need to monitor yourself. Also let them make the mistakes, because they're their mistakes to make and not ours, and sometimes it is not our place to correct them." FF described a safe environment as "one where I know people" and
"seeing other people make mistakes. …If I went somewhere and…everyone was perfect, I would probably feel intimidated." CH stated that students need "a less threatening environment" in order to explore mistakes where they are not made to "feel nervous or intimidated." AS contended:

It comes down to the way we, as instructors, support students through making mistakes. I mean when I think about the instructors where I felt safe, I felt like they were there to teach, that they were not there…trying to intimidate me into failing.

EE also talked about the need to avoid intimidating students, describing how students:

Need to have a sense of trust with the instructor, that the instructor will keep them safe and…in this environment…making mistakes is going to be supported and managed effectively so they are not going to be humiliated.

EE emphasized that when mistakes are made, "I need to know that when I do make them, I have some sense of freedom to make them,…and…have the opportunity to learn from them verses, 'you've made a mistake, you're gone'.” BJ recommended:

Trying to help the student unpack elements out of context, the situation, what was going on before, what was going on in their thinking, how were they feeling. …Try to bring lots of levels of…exploring to what the mistake was…in a non punitive tone…helps the students sort of be curious…and look at the mistake from multiple perspectives;

as a way of setting up a safe learning environment.

Leveling. Leveling learning was described by several participants as critical in promoting a safe and not too overwhelming learning environment. Leveling involves
balancing students learning needs with what is expected at the various stages of their professional education process so that students are not completely overwhelmed. DB described her mistake as a failure to consider the level of her students. She stated:

> I thought it would be important to challenge them, however, I was oblivious to the leveling concept of where their learning's at…I just assumed they knew stuff. …At one point one student just burst out into tears and said I can't handle this, this is so hard…I don't think I can do this program. …It was a big eye opener for me. My mistake was expecting too much from that level of student.

FF describes trying "to put students in a situation so that even if they do make a mistake…its ok…it didn't matter at all, so you see its ok to make mistakes." She states that if it is "so difficult for them, and its so stressful that any learning that they have or … any good…they could do is impaired right there…because their anxiety level's so high. …We have to ease them in slowly."

*Mentorship.* Mentorship and role modeling as methods of providing support was raised as helpful in contributing to a safe learning environment. CH said, "I think mentorship is excellent…we critiqued each other and they were all very supportive." EE asserted:

> It's about the approach of the instructor. It's about class management and how they perceive the instructor managing other students who have made mistakes. It's like, if you make a mistake and I queer you out about it [give someone a hard time], then chances of the other student being willing to risk making that mistake is going to be a bit limited.
EE added, “Its what you say and what you do, what you don't say, what you don't do…how you are respectable or respectful to students. …You try to create that sort of learning environment [for] people…to know that’s ok”. BJ states that parameters need to be set up “early on that it is ok (to make mistakes). …Set up a norm in the classroom right away…its ok, you're not going to be humiliated…it's not about being ridiculed.” BJ suggested, "trying to be present…not being overly reactive right away"; help students to feel safe.

*Role modeling fallibility and expressing humility.* Role modeling one's own fallibility and expressing humility were also mentioned by several participants as key to setting up a safe environment in which students can then feel freer to acknowledge their errors. AS states, ” It is really just having the maturity to say, 'I don't know everything', and important to role model that.” DB recommends learning, "big time to be more humble" and honestly saying "what's working here and what isn't." She adds “sharing and being humble with ourselves and giving examples about our errors" is important because if we “expect trust, the only way we are going to facilitate that is to role model it.” ES reminds herself of her fallibility by asking, "What am I about and do I know everything?" and often will "preface something and say I am not the expert here." FF suggests, "Staying in the clinical area (continuing to practice) because then those current mistakes help me appreciate and empathize with my students stress going into an unknown situations." CH thinks it is imperative that, "as nursing faculty we need to keep reflecting on how much we knew when we started practicing. Wow- I was stupid and missed a lot of information."
Balance. Several participants also pointed out that being permissive is not conducive to a safe environment for either the students or their clients. CH observed that "sometimes you have to be a little harsher than other times. …If it was a mistake that was just blatant poor protocol then sometimes you do have to kind of lay it out and say this absolutely can't happen again". This is consistent with EE's comment that part of promoting a safe environment requires "on going communication…when you talk about risk." BJ adds, "Let them know what the consequences are right off. …This does not necessarily mean you have failed the course. I think having information like that right up front…helps them to calm." DB stresses the need for a balanced approach:

In order to learn you need to feel safe, you need to feel supported…but at the same time you don't want to be so slack that its all about being a friend, and being cool, and being ok with the student and just letting it go. …There needs to be a balance.

Theme 6: A trusting relationship is key. Without a trusting student instructor relationship, learning, at least the learning intended by the teacher, cannot occur. Mutual respect is key to promoting a trusting student instructor relationship that promotes what was described as a ‘power with’, or more egalitarian student centered learning situation. The power is shared, as opposed to a ‘power over’, more traditional teacher centered learning environment. Additionally, good communication that validates and makes expectations really clear is vital, especially during the times when students need to receive feedback critical of their efforts.

A trusting instructor-student relationship. All participants highlighted the importance of a trusting instructor-student relationship as key to creating the safety
needed for exploring mistakes. DB stated, "they know I genuinely care about the students, I really care about how they are. . . . It's building the relationship and the trust, and role modeling. . . . saying, 'I don't know . . . let's go look that one up together.'" Both AS and BJ refer to the importance of avoiding 'power over' situations. BJ stressed the need to make the learning "more exploring...as opposed to coming at it as a power over perspective". 

AS recalled when she was a nursing student:

If I made a mistake...or whatever, it would be a discussion and it wouldn't be a 'you did this wrong', it wasn't, it didn't feel like a power differential even though obviously it was. . . . But it didn't feel like you're my parent telling me;..there was no shaming experienced.

She also stated that, "I think it goes back to that top down culture...I really try to look at them as not equals, but that I am partnering with the student[s] to get them through the program." She emphasized the need for faculty to not wield the power they have in punitive manner and instead suggested, "we have to look at the way we have relationships with students...the way we approach them, the way we give them feedback and they way we are,...critiquing them". Added EE, "If you don't have that working relationship and you are working with someone who you know is that kind of really staunch, hard ass kind of...you're going to be watching your p's and q's and...you're going to be a bit more tentative" and not take risks. DB states that it is important to avoid "finger pointing...negativity" and instead provide "support".

Good communication. All stated that good communication is vital and that mistakes need to be talked about. DB uses mistakes, as "an opportunity not just to keep it in silence like it's a bad thing. When one student makes an error, ask them, 'is this
something we can talk about?" because everybody needs to learn from it so it’s not this big taboo thing." CH stated, “In order to decrease their anxiety…look at the positives" even though she knows, "initially they will have to just grin and bear it (the dissonance)”. AS recommends, "We simply talk about it, so we will have a conversation that this is the room you get to make mistakes in. This is where you get to come and screw up…putting that on the table." Good communication enhances the relationships that allow students to trust and go on to take the necessary risks that will allow them to learn. BJ emphasizes the need for "teaching students the language and frameworks to consider the aspects of a mistake with curiosity (as) a way to support more comfort with cognitive dissonance…suspending judgment as the first reaction" in order to promote learning. FF adds that using "the language and frameworks" not only allows students to "better critically think about or consider their mistakes" but it also:

- Decreases the emotional impact and encourages you to look at all of the factors…because they have the framework to deconstruct the mistake or success; they are able to learn from it. It is not threatening. There is no denial and mistakes are certainly not a sign of stupidity.

Opportunities for debriefing after a mistake has occurred need to be provided as part of good communication. FF believes that “students…actually need a debriefing once they've made a mistake so I make sure we do have a private debriefing. And then, if the student feels comfortable enough we usually share their mistake in post conference so other people can learn from it." DB states it is important to "praise publicly, criticize privately" whenever such debriefing is needed.

Theme 7: To prevent and resolve mistakes requires knowledge and resources.
While all agreed that mistakes are bound to happen and that great learning comes from them, all articulated that it is important to resolve the mistakes, to both help prevent them in the future, and exercise our ethical duty to inform those affected thus fostering a more trusting relationship with clients. In order to resolve mistakes, all expressed a need for increased knowledge and other resources, which given the current climate of cutbacks and service reductions in both post secondary education and healthcare, was acknowledged as extremely challenging to achieve.

AS stated, "knowledge is huge" if mistakes are to be dealt with effectively. She suggested that one way of maintaining knowledge is "staying on in the field and what is going on" – to maintain a professional practice. CH adds, "when you get [students] into the clinical area they have nothing to compare it to, they have no baseline, they have no prior knowledge to build on,…everything is so new it is like walking into another world." CH would like to discover the secret to ensure that theory is transferred effectively to practice. She attributes students' inability to do this as contributing to mistakes and inhibiting their ability to resolve them. DB stressed that while students "also need to feel safe, and also need to feel they are not there to be perfect, that they are not going to know everything,…[they] should know a lot." Additionally, DB stated that in order to be accountable and apologize to clients, "to never hide it", students have to have enough knowledge to recognize they erred and that they are duty bound to resolve it.

Other resources needed to prevent and resolve errors are more humanpower. DB recounted, "There is research being done [that] the instructor student ratio is inadequate and unsafe for the clinical environment today and the acuity levels." With a smaller group she said, "You can have closer supervision, you can have a better working relationship
with the student. …You're not carrying as many patients. …We are working in an environment where we are continually …short staffed. That adds to mistakes." To this, DB adds issues such as high ratios of inexperienced to experienced staff and lack of educator support lead to an increase in errors. FF confirms DB's observations, stating, "Having the resources around …more experienced nurses would be great but at this point in our careers we're it." Without adequate support in clinical areas, all agreed that preventing and adequately resolving mistakes will continue to be a very real challenge.
Chapter Five

To Err is Human; To Forgive is Divine.

- Alexander Pope

Discussion

The participants in this study openly discussed the phenomena of how they experienced mistakes and expressed an interest in challenging openly the perfectionist culture of shame and blame that prevents open and honest conversations about mistakes in health care settings. All six participants described mistakes as complex phenomena that are not just the fault of individuals but also the culture and environment individuals must operate within. Mistakes emerged as something that evokes cognitive dissonance accompanied by a variety of possible emotional responses. All concurred that to make mistakes is human and a necessary and unavoidable part of the living and the learning process. All also emphatically endorsed mistakes as an opportunity to learn and grow if the right attitude is present in the learner. That attitude included being honest and humble enough to admit a mistake, but also ensuring adequate preparation and knowledge acquisition to correct the error and put in place strategies to prevent it occurring again.

All stressed that in order to learn from mistakes a trusting instructor-student relationship is critical and must exist within a safe and supportive learning environment. In order to establish a safe learning environment, adequate resources must be available and transparent and clear communication needs to be fostered.

Consistent with a Faulty Model System, the participants acknowledge that it takes more than the individual to ensure that mistakes are both addressed and prevented (Crigger, 2005). They agree with Heidegger (Neilsen, 2007) that mistakes rarely occur in
isolation or just to one person; they are part of the wider world in which they practice. Participants spoke about the culture of intimidation and humiliation, described in the literature as the culture of shame and blame, that inhibits students and practitioner from readily coming forward and airing their errors (Crigger, & Meeks, 2005; Kroll et al, 2008). Two participants described the need to move from a power over stance, where mistakes are viewed as something to be punished, toward a power with perspective, where mistakes can be examined with curiosity and reflected upon in order to discover what went wrong and why, and what could be done differently. By reflecting on the implications of the mistake, the participants suggested that critical thinking and problem solving is engaged, rather than avoidance and defensiveness. In such a climate, students are more likely to overcome self justification and to admit their errors, share them with others so all can learn from them, and then move forward in their journey toward being a more experienced practitioner.

Making mistakes evokes dissonance and creates tension resulting in a multitude of different feelings which arise when what the individual expects to happen does not, resulting in an error (Tavris and Aronson, 2007). The participants described feeling embarrassed, stupid, overwhelmed, dreadful, sad, resentful, uncomfortable, and racked with doubt and fear. These feelings resulted from failing to meet their expectations of achieving perfection in practice and from the concern that their errors may hurt someone, creating discomfort and dissonance.

In spite of all of these negative feelings, consistent with the literature (Berman, 2006; Crigger, 2004; Kroll et al., 2008; Neilsen, 2007; Tavris & Anderson, 2007; While, 2003; Ziv et al., 2005) the participants all declared that making mistakes is not only
human, but also a necessary part of the learning process, allowing growth and development to occur. Such learning can not only enhance critical thinking and problem solving, but also increase self awareness and reflection, and consistent with Heidegger’s view (Neilsen, 2007), creates change in both the individual and the environment that surrounds them. The participants spoke of the challenge Berman (2006) outlined - on the one hand, the need to hold students accountable for their actions in order to protect clients, and on the other hand, creating an environment that provides freedom to talk about and learn from mistakes so that the mistakes can be managed and prevented. Individuals must be held accountable for their contribution to the mistake, but consistent with Heidegger's assertion that mistakes do not occur in isolation but as part of the wider world, participants indicated the ramifications of a culture of perfection, with a power over approach, that results in a shame and blame mentality.

In order to admit mistakes and thus learn from them the students have to have integrity and be willing to be held accountable. While learners cannot be expected to know everything, they must come as prepared as possible, and in the words of one participant "know a lot." They must be able to take risks and tolerate the distress that making a mistake invokes. They have to have enough knowledge and understanding to recognize a mistake when it is made and take their responsibilities seriously. They must be able to engage in self-reflection in order to overcome their own tendency to self justify and be defensive. The ability to critically self-reflect is also necessary in order, as another participant asserted, "to unpack" the error, and to take away the learning that may emerge as the consequences of the mistake are explored.
One of the most critical concerns for the participants is whether learning did in fact emerge once a mistake had occurred. The participants accept that mistakes happen, but were very interested in the context in which mistakes occurred. In examining why errors occurred, the participants want to know the following: is it a question of confidence or competence; is anxiety at play; is the learner lazy or indifferent; has the learner done his/her homework; did the mistake occur because of carelessness or lack of attention? Following on, how the mistake is managed was of pivotal importance. While the participants did not articulate a set protocol as Berman (2006) does, they outlined similar expectations of how to deal with an error – admit to it, learn from it, rectify it, forgive it, and carry it forward so hopefully the mistake does not happen again. Like Berman, one participant emphasized the need to not only acknowledge the error and correct it, but to tell those affected and apologize.

Aligned with the tenets of an emancipatory pedagogical approach, the participants all spoke about the need to create a safe environment that gives students the freedom needed to explore and discover, the support required to take the necessary risks, and the language and a framework for resolving errors when they do occur. All asserted a trusting instructor student relationship is the key. Consistent with Noddings (2002), the participants agreed that how students are treated by their instructors will determine in large part whether the attributes needed for dealing with mistakes will actually manifest. The participants described a safe and supportive instructor-student relationship as one that is respectful and validating, where prior student experience and skills are acknowledged. Intimidation that leads to humiliation is avoided at all times. A sense of trust must be promoted and can be established in several ways: being sensitive to
individual learner's needs; not expecting too much too soon; using humour to break the tension; demonstrating that the students are cared about; and getting to know the students a little bit beyond the classroom or clinical setting. In a safe environment, participants described encouraging students to explore multiple layers and perspectives of the circumstances involved in mistake making in a non-punitive fashion that fosters curiosity rather than avoidance.

Reflective of the components of a moral education as described by Noddings, (2002), the participants stressed that mentorship and role modeling are important elements for creating a safe learning environment. Indicative of critical dialogue and a narrative pedagogical approach (Dickelmann, 2004; 2005; Ironside, 2003; Schreiber & Banister, 2002), the participants agreed that instructors have to be prepared to be challenged, questioned and able to admit they don’t know everything. Students also have to see instructors managing mistakes, both theirs and their students, in an effective and respectful manner. Several participants expressed that it needs to be made clear from the outset that it is okay to make mistakes and allow students to do so, and like Ghandi, one added, "sometimes it is not our place to correct them." A number of participants stressed the importance of instructors describing their own stories of fallibility and how they were humbled in order to promote discourse about errors.

To develop a trusting instructor-student relationship and to create a safe learning environment, the participants all emphasized that good communication was critical. Mistakes have to be talked about. Consistent with Berman (2006), Crigger (2004), Knoll et al. (2008), and Ziv et al. (2005), the participants expressed that mistakes need to be
discussed openly, shared with others, put on the table, so, as one participant stated "it is not this big taboo thing".

Like Berman (2006), two participants referred specifically to developing the language and frameworks necessary to discuss mistakes, their impact and consequences, in a manner that reduces the dissonance experienced, and allows self justification to be overcome. In this way critical reflection and thinking can occur in a non-threatening climate. One also stated that it is important to provide opportunities to debrief – first in private, then, with the student's permission, in public, so others can learn from the mistake as well. All stressed that if we want more than 20% of our students to admit errors (Tabak & Reche,1996), communication must be clear, transparent and on going about what the risks are, and the consequences of mistakes may be. However, making a mistake does not mean the student will be evicted from the program.. Additionally, in those rare situations where a student is at risk of failing, clear and compassionate communication was deemed vital to ensure that the student understands what is expected and is given the opportunity to redress it.

Several spoke of the need for adequate external resources to be in place if mistakes are to be prevented and utilized as learning opportunities. One participant pointed out that if instructor-student ratios are too high, it is impossible to provide adequate attention to all the students in order to foster and maintain the safe environment described above. Another mentioned the lack of clinical educators available in clinical settings as a handicap to ensuring that adequate knowledge and preparation can occur to help prevent errors. Inadequate staffing levels in the hospitals, combined with increasing acuity of the patients was mentioned by one participant as leading to harassed staff who
are less patient with students, reducing respectful communication opportunities and contributing to more errors and the culture of shame and blame.

The participants’ perception of the impact that a lack of resources has in the current health care environment is supported by the literature. In a study of 43,000 nurses from five countries, 17,000 of whom were from Canada, the rest from the US, England, Scotland and Germany, similar concerns were noted (Aiken et al., 2001). Aiken et al. (2001) embarked on their study shortly after the Chicago Tribune published a series entitled “Nursing Mistakes Kill, Injure Thousands” (p. 43). Their study found that what worried doctors and nurses the greatest was inadequate staffing levels of nurses. Aiken et al. report that this particular finding was also noted by US nurses in a report published by the Institute of Medicine, titled *To Err Is Human*, which concluded that reduced staffing levels of nurses is not safe for patients. Aiken et al. reported nurses were also concerned about inadequate levels of support staff, particularly front line managers who are a conduit to higher levels of management who convey nurse’s concerns, and provide support to help problem solve in the clinical arena. The working conditions that result from what was described by Aiken et al. as “industrial models of productivity improvement” ignore nurse’s concerns – symptomatic of the oppression described in Chapter 2. They state that the failure to address nurses’ concerns is leading to reduced retention, especially of the most young and the most experienced (or old) due to decreased job satisfaction and low morale (eg burnout), overwhelming work loads with constantly increasing levels of patient acuity, and unresponsive management who fail to listen to feedback from nurses and recognize the nurses contributions. The study also
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reports that in this resource-scarce climate, mistakes by nurses, and the adverse effects that result, are becoming more common (Aiken et al., 2001).

The seven themes that emerged from the data analysis indicate that the six participants fully subscribe, even though they didn't use the term, to what Crigger (2005) describes as a Faulty Model System that views mistakes as complex phenomena which involve both individual and organizational activity as contributing to mistake making. The participants articulated, consistent with the literature, the nature of mistakes as part of being human, unavoidable, and necessary for learning to occur. The participants also advocate for emancipatory pedagogical practices that create a safe and more egalitarian learning environment that fosters critical dialogue and supportive, trusting instructor-student relationships that provide the language and framework within which critical dialogue about mistakes can take place. Worth noting however, is that currently, most of this work continues to be done in the shadows, as the quote by DB at the beginning of Chapter One makes clear. Psychiatric nursing instructors are not talking about mistake making in open forums or with their colleagues and students in clinical and classroom settings. This topic continues to simmer below the surface, with each individual sensing that others may be thinking and behaving the same way. However, due to the overriding power of the health care system’s dominant culture of perfectibility which continues to delude itself that more can continue to be done with less, placing the blame on the individual practitioners rather than the wider culture, psychiatric nurses and nursing instructors will continue to avoid discussing their experiences with mistakes openly.
Implications

The possible implications of this research are that by understanding what making mistakes means to psychiatric nursing instructors, their ability to risk making mistakes in classroom and clinical situations to enhance learning will increase. By reflecting on the meaning that mistake making has for them, psychiatric nursing instructors' ability to tolerate the dissonance that arises when their students make mistakes may increase. By exploring and reflecting on the meaning of mistakes, the participants may come to understand that making mistakes can be more than a negative experience. They may begin to realize that making mistakes can actually contribute to their understanding and help them, and their students, develop, as the Buddhist quoted earlier suggests, good judgment. In the clinical setting, it is hoped that the findings will help to spur nursing instructors to create an atmosphere of discovery and support so that mistakes and their consequences can be explored in a safe and respectful manner in order to improve the student's practice and patient safety.

It is also hoped that by considering the meaning of mistakes, and their value to learning, psychiatric nursing instructors will speak up and challenge the culture of shame and blame that has arisen out of the dominant perfectibility model. Acknowledging the dominant culture’s legacy, that the traditional or perfectibility approach to the delivery of health care is neither safe for patients, nor helpful for learning, is key. By engaging in dialogue about the nature of mistakes, psychiatric nursing instructors might, in the words of David Greenberg, take themselves and their students, “out of their culture and re-norm… them” (Gladwell, 2008, p. 220). As the emerging research indicates it behooves us to do so (Aiken et al., 2001; Knoll et al., 2008; Tavris & Aronsen, 2007; Ziv et al.,
Failure to engage in a dialogue about the phenomena of mistakes not only inhibits learning, and leads to negative patient outcomes due to increased morbidity and mortality, but also contributes to higher rates of patient dissatisfaction in less severe situations, leading to more lawsuits (Aiken et al., 2001; Tavris & Aronson, 2007). The move to acknowledge errors in health care is starting to get under way. Ontario, along with several US states, now have laws in place that encourage health care providers to apologize for their mistakes by stipulating that such utterances cannot be held against them later in court (Tavris & Aronson, 2007). The more practitioners who brave talking about their experiences with mistake-making, who come out from behind the Berlin Wall that is currently in place, the greater is the potential to re-norm the culture of perfectibility. It will move us toward a climate that embraces mistakes so that they can be discussed openly and non-punitively, managed proactively, and dare I say, celebrated for the wonderful learning opportunities they are meant to be.

Additionally, research could also expand to involve more nursing schools to see if similar themes emerge. It would be interesting to do an ethnographic study to determine how psychiatric nursing students as a cultural group view the learning process that arises from making mistakes.

So while to err is human and to forgive is divine, it is what we learn from our mistakes that allows us to move out of the darkness and into the light of discovery, but only if we are brave enough to open the dialogue.
References


Appendix A: Sample Questions

Time of Interview:
Date:
Place:
Interviewer:
Interviewee:

Questions:

1.) Describe a situation in which you made a mistake:
   a. How did you feel?
   b. What did it mean to you?
   c. How did you deal with it?

2.) How do you perceive mistakes?

3.) What positive impact does making a mistake have on your learning?

4.) What negative impact does making a mistake have on your learning?

5.) What characteristics do you attribute to someone who makes mistakes?

6.) What characteristics do you attribute to someone who admits mistakes?

7.) What kinds of conditions would make you feel more comfortable about risking making mistakes in the classroom?

8.) What kinds of conditions do you think would make your students more comfortable about making mistakes in the classroom?

9.) What kinds of conditions would make you feel more comfortable about mistakes made in the clinical setting?
10.) What kinds of conditions do you think would make your students more comfortable about mistakes made in the clinical setting? Do you think they should be made more comfortable?

11.) What aspects about your psychiatric nursing experience increase your anxiety about making mistakes? What would decrease it?

12.) What aspects about the psychiatric nursing experiences increase your students anxiety about making mistakes? What would decrease it?

(Adapted from Creswell, 2007, p. 136)