Multiple Ways of Knowing Caring: Nursing Instructor's Clinical Evaluations

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We accept this thesis as conforming to the required standard

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ABSTRACT

The intent for this thesis was to construct an understanding of how clinical nursing instructors evaluate caring. The question served as an invitation to think about how multiple ways of knowing inform the instructor's understanding. A hermeneutic inquiry was employed to construct meanings of caring and further engage those meanings to understand how they have an impact on the clinical instructors' evaluation. The interpretive inquiry began by considering the difficulty participants experienced when asked to describe caring but found a worthy vehicle in the use of story to expose their meanings of caring. From the stories the themes of being involved, qualitative touch and the gift of time were suggested as characteristics of caring. A note of caution was assumed to remind us that these themes were always set against the backdrop of the context and situatedness of the story. Evaluation of caring was then explored and several salient features from those conversations were captured. Instructors revel in the recognition of caring in their nursing students and cannot always articulate specifically what that recognition is based on. Caring is a recognizable yet intangible substance or quality which does not lend itself to definition or abstraction. The experience of caring is larger than a sum of its parts and must be viewed in wholeness. It is impossible to extract the essence of caring without reference to the whole. Caring becomes further distorted when viewed within the reductionist evaluation framework of behavioral objectives and we must find other means, forms of inquiry and ways of knowing for accessing this aspect of student nurses' practice.

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Acknowledgements

...the eloquence of the text may contrast sharply with the toil, messiness and difficulties involved in the research/writing process. 'And this took that long to write you say?'...

Van Manen, 1990, p.8

Whatever eloquence may be found by the reader in this text can be largely attributed to Dr. Antoinette Oberg's ability to inspirit the writer within. Her ever so gentle nudges were integral to furthering my understanding of the question I raised and my attempts to explore it. Her patience in the face of my plodding efforts to complete this work were remarkable and highlight the respect and trust that she bestows to her students.

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A special thank you to my four participants for sharing their time, thoughts and stories with me.

There are other very special people, family and friends who refrained admirably from asking how my thesis was progressing (when it wasn't). Their words of support and encouragement were greatly appreciated, both at the outset of my educational project, and as I wound my way towards completion.

I would like to dedicate this thesis to my parents, Jim and Catherine Clark who exposed me, in thought and deed, to my first meanings of caring.

PREAMBLE

A Day with Allison

I supervised Allison, my student, in giving a morphine injection through a subcutaneous injection port today. This patient receives her analgesic every four hours for intractable terminal pain, mostly in her abdomen but sometimes the pain will gravitate to her back. It was the first time I had spent any time with this patient. Even in the last stages of her illness she was beautiful, though no doubt only a glimmer of her former self. She has that kind of skin which I admire. Soft, lightly tanned with little lines of wisdom forming around her mouth and over her forehead. Her skin had been well cared for over her fifty some years. I can tell. Her fingernails were manicured which is unusual for someone so ill. Her legs were shaved as though prepared to draw on silk stockings and go out for an evening. I discovered later that a long-time neighbour had spent her visit performing these intimate little deeds of kindness for her. I was warmed by her friend's gestures.

I have a lot of confidence with Allison though we have only spent three clinical weeks together on this busy oncology unit. She has a quiet assurance about her but knows her limitations. There is a twinkle of laughter in her eye but she is ever so serious when discussing patients. Yesterday we had spoken together about her "assignment", and she felt wonderful about her day spent together with this particular patient. She spoke about the woman's inability to articulate her thoughts at times. The patient has had intermittent periods of confusion, sometimes she is simply unable to speak for whatever reason and then there are times when she is surprisingly lucid. Allison was pleased that she had been able to communicate with her through reading body language, anticipating her wishes and listening very patiently. Allison was, in fact, glowing and had requested that I continue to assign her this patient for the following week. I didn't need to remind her that the patient might not be here next week.

Although Allison had been assigned to this patient for two days now it was the first time I had spent any time with them. I noticed how gently Allison spoke to her, explaining what we had come to do. Cautiously she moved back the bedcovers to reveal the injection port secured in the patient's left thigh. There was some bruising around the site and Allison was concerned that we should relocate the small appliance lest we cause

yet more pain. The woman lay very relaxed and tolerant as we discussed the injection site. She and I exchanged a look which I have seen on more than one patient. It is a knowing look, a maternal look, an empathetic look, and sometimes it is a protective look, but not on this occasion. Patients often become quite protective of their student nurses, especially when the instructor is around.

Allison and I decided to leave the site for the time-being. We were running out of available areas and it would do for one more injection at least. I left them then, they were content to be together without an intruder. There was a connection between these two people. I could feel it in their exchanges. A feeling of mutual respect and concern for one another pervaded.

By the end of the day I was doing my routine walk around, visiting with patients, collecting students for post-conference, and listening to my students give their final report to the RNs for the day before they left. I approached Allison's room. The drapes were pulled and it was quiet within. Rather than calling out as I usually do I pulled the drape aside a wee bit in case the woman was asleep. There was Allison bending over her patient. They were looking at one another intently, the woman's hands reaching up and cradling Allison's cheeks, almost stroking them. Allison reached her own hand up and placed it upon the woman's. I didn't interrupt as they said their goodbyes for the day.

CHAPTER ONE

INTRODUCTION

In the opening preface to yet another book dedicated to rescuing caring in nursing, Montgomery (1993) states: "Unfortunately during our fascination with the promise of technology, we lost sight of the importance of this human element" (p.ix). The human element she is referring to is caring. Nurse educators too, are responsible for a compromise which tends to devalue caring by primarily upholding the empirical, scientific and rational aspects of the work of nursing (Watson, 1990). By focusing predominantly on the cognitive-technical aspects of nursing, educators have left themselves in the untenable position of (almost) placing cure above care. In the practice setting with students, clinical nursing instructors are bound by the constraints of the current educational paradigm. That paradigm provides methods for judging the worth of nursing practice, for the most part, on the basis of behavioral objectives and competencies; in essence from a rational empiricist standpoint. Knowing intuitively and experientially that caring cannot fit neatly into a behavioral objective or competency, I wondered how clinical nursing instructors reconcile the dialectic of evaluating students' caring within this current educational framework. The anecdote which precedes

this text is one example of the encounters and observations which clinical instructors experience in the course of their everyday shared experiences with nursing students. In the reading of this vignette the reader will recognize the underlying tone of caring which pervades the relationship between the student, instructor and patient. It is a pointing to this tone, either in its presence or absence, which directs my question: How do clinical nursing instructors evaluate their students' caring?

Focus on the Question

There is indeed a great desire to understand how to evaluate the "caring" of students, given the high profile of that concept in nursing literature and discussion. For example, some of the following titles to current educational literature alert us to the prominent position which caring has explicitly assumed: Human Caring as Moral Context for Nursing Education, Beyond Dualism: The Dialectic of Caring and Knowing, and Toward a Caring Curriculum: A New Pedagogy for Nursing. There remains a longing to lay claim to caring as the ultimate attribute, the shared perspective, and the essence of what nursing is, and what nurses do. If caring is to become the guiding framework for nursing practice it seems very relevant

and appropriate to ask how nurse educators evaluate the caring of student nurses. This question serves as stimulation for the on-going dialogue of how nursing instructors might evaluate students in the future if behavioral objectives cease to provide the backbone for evaluation.

The question is an invitation to think about and acknowledge how different ways of knowing inform instructors' understanding in clinical evaluation. The ways of knowing identified by Carper (1977), and Belenky, Clinchy, Goldberger & Tarule (1986) initially served as a means of opening my mind to possibilities of knowing, thinking and being but these writings did not limit or necessarily frame the exploration. The proposal for research was shaped by the thought that there are multiple ways to understand caring, to recognize caring, and therefore to evaluate the caring of students in their clinical practice.

This research enters directly into the dialogue already occurring in nursing education which posits that caring should become the epistemological and ontological frame of reference for nurses in practice. That is, caring should be the underlying theme of both the nurse's knowledge and being in practice. "It is here in our knowing and being that the moral and human science ideals of human caring must take root if caring

values are to reshape higher education and the larger health care system" (Bevis & Watson, 1989, p. 43). Therefore, according to Watson, caring must become the underlying assumption from which nursing curriculum embark in the mission to prepare nurses for practice. Nursing scholars leading the movement (Bevis & Watson, 1989; Leinenger, 1989; Chinn, 1991; Gadow, 1989 and others) have found a receptive audience in nurse educators to move caring front and centre as their explicitly stated foundation of nursing. In my work of coordinating a new curriculum based on caring, I can almost hear audible sighs of relief from nurse educators who endorse giving substance and explicit value to the human quality of caring. Nurse educators nationally and internationally are embracing a caring framework for nursing education with anticipation and enthusiasm. As Hills has stated, "We are reclaiming our philosophical roots" (Hills, 1993).

Bevis (1989) declares that:

> Preeminently, however, it is caring that must be reoriented toward a new vision of the whole person, body, mind and heart alike, and pervade the curriculum structure and form its ethical content. It is no longer sufficient for nursing to concern itself with anything less. It is no longer sufficient for nurses to be anything less that this vision entails (p.xiii).

In nursing education which places caring as the prime directive, and advocates that nurses and 'would

be' nurses cannot ".. be anything less.." than caring, what manner or ways can nurse educators embrace to ensure that their successful students are caring? The traditional evaluation paradigm subscribes to the identification or objectification of students' practice. As I discuss later in the text, caring does not lend itself easily to objectification. Evaluation of caring becomes a critical element in the dialogue when we envision a curriculum for nurses based on caring

Central Assumptions Guiding this Question

Prior to, and throughout an inquiry it is necessary to outline the assumptions you begin with in order to understand the orientation with which you approach the inquiry. These assumptions will play a large role in not only the question raised but the way one understands the question and the methodology adopted in exploring it. Moccia (1988) suggests that the research methodology one adopts in inquiry should reflect the epistemological and ontological views of the world held by the researcher. The following discussion explicates the most important assumptions I began with in exploring how instructors evaluate caring.

I am a nurse. As a person in a helping profession

I concern myself with humans and therefore require an orientation which embraces and potentiates the human experience in all of its unique and multiple realities and forms. More fundamentally I approach the human world not by wanting to explain it but in a desire to understand it. Explain means to make plain or evident, while to understand means to apprehend the meaning of; or to discern by the mind (Webster, 1984). In human inquiry it would seem presumptuous to claim the ability to "make plain or evident" all of the unique and multiple realities and forms that the human condition can take. Seeking understanding, on the other hand, seems a more reasonable approach. Understanding takes on a compassionate tone, it has an empathic quality to its meaning. There is a suggestion of mutuality or relationship in the appreciation of the human condition. Understanding is made more possible through relationship, (Belenky, Clinchy, Goldberger & Tarule, 1989) and by acknowledging the "other" as subject with their own unique composite of knowledge, experience, context, and situatedness. Gadow,(1989) states that "the only way we can know other human beings without reducing them, as science must, to the status of object, is to engage them as subjects, as beings who are each an 'I' and not an anonymous 'one'" (p.8).

The contrast between explanation and understanding is made more evident in the distinction between a human science and a natural science (VanManen, 1990).

> Natural science studies "objects of nature","things," "natural events" and "the way that objects behave". A human science studies persons or beings that have consciousness and that act purposefully in and on the world by creating objects of meaning that are expressions of how human beings exist in the world (p.4).

Given that I want to understand, as opposed to explain, and that I assume the means to understanding is through relationship, how do I then approach the question, what is the nature of knowledge? However much I struggle with this age old question, for the purposes of this study I must outright reject the positivist claim about the nature of knowledge. A positivist perspective would state that knowledge does exist "out there" (Guba & Lincoln, 1989) and if we look long enough and hard enough we will find it, and can know all that there is to be known. The human world for me is far more complex than presumed by this positivist claim as it serves to provide the knower with explanation. Further, this positivist claim separates the knower from the known, and the subject from the object. As my orientation seeks for understanding made possible through relationship, the separation of the knower and the known is antithetical

to my perspective.

My views of knowledge are closely aligned with constructivism which "denies the existence of an objective reality; asserting instead that there exist as many such constructions as there are individuals" (Guba and Lincoln, 1989, p.43). Constructivism highlights the uniqueness of individuals' knowledge because it becomes a composite of the attempts to make sense of experience and is thus grounded in past experiences, belief systems and values. Context and situatedness must be taken into account.

Constructions of truth will be modified and changed in the process of interaction. "That is, the knower and the known...are co-present, each modifying and shaping the other" (Watson, 1990, p.43) In the act of inquiry therefore "the findings of a study exist precisely because there is an interaction between observer and observed that literally creates what emerges from that inquiry" (Guba and Lincoln, 1989, p.44).

One central assumption of this exploration is that *multiple* ways of knowing or multiple constructions of reality are not only possible but do find a place in nurse educators' understanding of their students' caring. Openly seeking the possibility of multiple ways of understanding reality is to acknowledge that

something in addition to traditional, empirical knowledge informs the knower. Personal constructions of meaning are derived in large part from life experience and these constructed realities will play a role in the practice of professional nurses. People create the meaning of the moment from a composite of experiences and reflections on life events, many of which are not only professional events but significant personal events. "The mind is an awesomely powerful instrument. It can evoke memories that are as real and alive and full of feeling as the day of their occurrence" (Bevis & Watson, 1989, p.163). These personal constructions of meaning or "created realities" (Guba & Lincoln, 1989) will have an influence on the nursing instructor's orientation to nursing and education.

Supporting and seeking multiple ways of knowing in nursing and nursing education is a reflection of my support for an alternative paradigm in nursing education. This alternative paradigm would acknowledge a departure from the reductionist medical model which has enraptured nursing education in the past. It would be informed by feminist theory, critical social theory (Campbell & Bunting, 1991) and phenomenology (Oiler, 1982).

In speaking of this new paradigm for nursing education Bevis states that to be effective, the

curriculum must "...acknowledge the wide variety of ways of knowing and must legitimize those things that are not empirically verifiable" (Bevis & Watson, 1989, p.2). Questions about multiple ways of knowing are being raised by others in nursing and nursing education (Benner, 1984; Bevis & Watson, 1989; Carper, 1978; Chinn, 1991). The conceptualization of what constitutes learning, knowledge, knowing and truth is shifting. There is a move away from traditional notions of science, away from rational-analytic discourse, and away from an a priori view of knowledge. Linear thinking and clear distinct unequivocal truths are being challenged as many voices seek to know through other patterns of awareness of our world. Either in response, or as a natural evolution to nursing education, these "other patterns" are becoming more prominently displayed. We see movement in both nursing and nursing education to consciously acknowledge and see worth in other ways of knowing. One example is the reluctant yet progressive increase in the use of qualitative methodologies for researching nursing phenomena (Leinenger, 1989, p.26).

The overriding assumption of this thesis is my belief that caring must be pursued as the central and significant feature of nursing. How caring is perceived in nursing is being questioned both gently

and vociferously (Morse, Solberg, Neander, Botoroff & Johnson, 1990). Caring as a topic has assumed a predominant place in the nursing literature in the past two decades. This vast increase in the caring literature, written by notable and respected scholars, provides a welcome forum for practising nurses like myself to add my voice to notions about caring. For it is because I care that I find myself situated in nursing. It is what makes nursing meaningful, real, and worthwhile for me. Benner's (1990) statement echoes my thoughts:

> Caring unleashes pleasure in the midst of work: a sense that some things are worth doing and some things are good in themselves - a uniting of means and ends. Care sets up what matters, what counts as stressful, what counts as coping, what being related and situated means (p.5).

When I initially pursued caring as a concept it seemed a soft, tender, compassionate "thing" that I did for patients. Exploring further by reading and (more) reflection on practice I am in process of enhancing that understanding. Aspiring to be caring drives me to action; it is the desire for good. It provides the conscience and commitment behind my nursing practice. When working with students I long to see that caring orientation in their practice. Though students do not have the experience nor the confidence to always be caring in the ways of more experienced and knowledgeable nurses (Benner, 1984; Noddings, 1984), I

look for the potentials and possibilities in students. Days spent with students like Allison (see Preamble: A Day with Allison) are affirming because I am able to witness caring easily and I revel in that perception. I believe students who embody (Gadow, 1990) caring will find more satisfaction and personal meaning in nursing. I also believe that they will be better able to serve, to comfort, advocate for, and enable their patients to live healthily or to die with dignity.

In summary my guiding assumptions for this human inquiry are the following:

- human science inquiry seeks to understand rather than explain
- understanding is possible through relationship
- truth is constructed by the knower
- there are multiple ways of knowing and multiple "truths"
- there is a need for an alternative paradigm in nursing education
- caring must be pursued as a significant feature of nursing.

Before beginning to more fully expand the question and explain the methodological considerations of this research, I will discuss the concept of caring in nursing, evaluation of caring in nursing and how multiple ways of knowing might have an impact on how

instructors evaluate caring.

CHAPTER TWO

WHAT IS THIS NOTION CALLED CARING?

The word caring has many meanings. In nursing it has recently been re-claimed as a critical concept in nursing research, theory, education and practice. The purpose of this section is to outline some of the meanings of caring in the nursing literature.

At once we recognize that caring is not easily defined. In the academic literature it is referred to variously as patterns of feeling of concern and regard for others, an interpersonal process or transaction; nurturing with skill; empathic awareness; a sensitive attitude towards another, a human trait, a moral imperative, an affect, a therapeutic intervention (Komorita, Doehring & Hirchert, 1991; Morse, Solberg, Neander, Botoroff & Johnson, unpublished, 1990).

Morse et al (unpublished, 1990) have analyzed the varied conceptualizations and theories of caring in nursing literature with a view to their diversity in meaning, scope and implications for practice. This collection is helpful to provide an overview to the caring literature. They have delineated five perspectives of caring which are: caring as a human trait, caring as a moral imperative, caring as an affect, caring as an interpersonal interaction and caring as a therapeutic intervention.

Caring as a Human Trait

Nursing theorists who view caring as a human trait see it as a universal human characteristic and an essential way of being. The first nursing theorist to actively explore caring in nursing was Leininger (1989) who, as early as the 1950's, was developing theory based on the assumption of human care being a significant influence on the existence of the human race. "I theorized that generic care must have been universal for Homo Sapiens' survival, and that professional care was a natural derivation from generic care" (p.22). One of the themes of theorists in this category is that nurses will become (or move towards becoming) more authentically human through human caring (Roach, cited in Morse, 1990).

Caring as a Moral Imperative

The second perspective identified by Morse et al (1990) is caring as a moral imperative which considers caring as a moral virtue in nursing. Caring is seen as "...the adherence to the commitment of maintaining the individual's dignity or integrity" (p.5). Caring is therefore not manifest as a set of behaviours or even traits but as the basis which preserves the person as subject and provides the motivation behind all nursing actions.

Caring as an Affect

Emotional involvement and an empathic feeling for the patient experience are emphasized from the perspective of caring as an affect. Furthermore, "these feelings must be present for the nurse to care" (Morse et al, 1990, unpublished, p.7). The nurse needs to become skilled in finding appropriate and sincere forms which are an expression of that caring and it is the emotion that motivates the nurse to act.

Caring as an Interpersonal Interaction

Some scholars (Benner & Wrubel, 1988; Horner, 1988) view caring as an exchange characterized by trust and respect whereby both the nurse and the patient are mutually involved in caring. It is considered reciprocal in nature in that both the nurse and patient are enriched. Intimacy, connection and concern is shared. Benner (1984) agrees. "Almost no intervention will work if the nurse-patient relationship is not based on mutual respect and genuine caring" (p.209).

Caring as a Therapeutic Intervention

When viewed as a therapeutic intervention caring is linked more specifically to the actual work of nursing. Theorists in this category (Gaut, 1988; Orem, 1985) are more or less task centred and caring can be

considered to be "done" regardless of the relationship between the nurse and patient, and similarly regardless of the nurses' feelings. Competence of caring is measured on the basis of the congruence between the perceived need of the patient and the adequacy of knowledge and skill of the nurse.

These five conceptualizations outlined are helpful as broad frames of reference to define caring in nursing. However, they fall short, as most theoretical frameworks will, in understanding the uniqueness of the personal experience of caring. Personal meanings of caring are drawn from our experiences and as such are individually constructed. Caring is often understood silently (but knowingly) in our being as nurses. That is why we feel discomfort in looking on at non-caring, or go home after a busy shift feeling unsettled as there was not enough time in the day to care-fully.

On Personal Meanings of Caring

From my perspective, to be caring I have to open up my self to the vulnerability of the other, and to the "subjectivity" (Gadow, 1989) of the other. It demands a knowing akin to Carper's (1977) patterns of the aesthetic and personal. There is a connection between being open to possibilities, empathizing,

striving for wholeness and integrity in relationship with clients and "being" caring. Openness to others in the world is not a behaviour but more a way of standing in relation to others; caring involves both attitude and activity.

Caring requires an orientation to others in the world, a mindful attuning of one to the other. It requires an immediate pre-reflective subjective response to another in a sensitive manner. It is difficult to "practise" caring in a lab setting to prepare for the immediacy of the moment which requires caring. While knowledge, theory and reason should inform the caring action or caring manner of a nurse, caring entails a more whole-some and embodied response by the nurse. The nurse brings not only collected bits of wisdom but her sense of self, emotion, experience and intuitiveness to bear on the attention to the other, her client.

As caring is at once not easily defined but recognized as both the core and the zenith of our existence as nurses, there remains a great need for all nurses to personally derive a definition of that concept and experience. I believe most experienced nurses do. The assertion that nurses construct their own meanings of caring through experience will become increasingly relevant to this thesis.

CHAPTER THREE

DISCERNING CARING IN CLINICAL EVALUATION

The preceding chapter briefly explored the conceptualizations of caring found in the literature and further asserted that nurses will construct personal meanings of caring from their own experience. This chapter will discuss clinical evaluation in nursing with particular emphasis on evaluating caring. Later I will address how multiple ways of knowing may have an impact on evaluation.

There is an historical tendency in nursing education to concentrate students' energies on therapeutic interventions, or "cognitive-technical competencies", which negate or devalue compassion and caring (Watson, 1990). In this way we tend to focus on aspects of "doing" caring, and neglect those aspects of "being" caring. In nursing education we seem to spend much time and energy making our evaluations, especially the written summative evaluations, explicit, objective and noticeably oriented to behaviour (Bevis & Watson, 1989). Instructors attempt to provide behaviourial objective data to substantiate the clinical evaluations of students. If a thought or notion about a student arises by way of a more discerning and perhaps less objective understanding, what do we do with it? Where did it come from and how do we make it go away? Or,

rather than make it go away, how do we apprehend those often subtle nuances of our assessments in order to transform the objective accounts of students' practice?

The preceding questions are but a few which I had pondered as a new nursing instructor orienting myself to the role of both guide and evaluator to nursing students. These musings also found a place in the conversation with other instructors. As a neophyte to nursing education, when I asked the question "How do you evaluate caring?" it gave rise to discussions which revealed a variety of answers. For some, the question caused a retreat to the rather safe and sanctioned world of evaluating students strictly from a behavioral orientation. Still others responded that you cannot evaluate caring. Yet another tack is to try to explain it through something other than reason. "Well you get a feeling about a student, you use intuition...or your gut just tells you..."

There have been attempts to make explicit ways to evaluate the caring of students. One author distinguishes between "caring for", referring to tasks performed, and "caring about", referring to the nurses feelings for the patient (Ungerson, cited in Komorita, Doehring, Hircher, 1991, p.4). These distinctions on caring may be seen as synonymous to the work of Morse

et al's (1990) to delineate the conceptualizations of caring and specifically those conceptualizations of caring as therapeutic intervention and caring as an affect. Ford, (Ford, cited in Komorita, et al, 1991,) classified "caring about" responses in a nurse focused open-ended questionnaire into two categories: 1) genuine concern for the well-being of others, including verbal and nonverbal communication, and 2) the giving of oneself. In addition, there were attempts to categorize and itemize those behaviours which characterize caring about. These lists included such items as: 1) touches patient when he or she needs comforting, 2) gets to know patient as an individual person, 3) encourages patient to ask questions...The list is long. In Ford's study 50 items were included to be sorted by the nurses into a Likert-type ranking system. While I do think that these behavioral indicators have some limited usefulness, I am unsure whether they can capture intact the experience of caring about another. "Caring about" another seems to me a more complete experience, much more complex than a sum of its parts. As a bystander witnessing the exchange between student nurse and patient together, I grasp something else in their encounter that cannot be apprehended by the appropriation of a behaviourial correct item. I want to sing, "There it's happening!

Caring is happening!"

My awareness that the student is "being" caring is an immediate integration of the "whole" of the picture I see before me. It is not always possible to identify the separate and objective details which form the experienced whole but I am confident with my impression. Noddings speaks of the opaqueness caused when we look cognitively at our intuitive knowledge. "Often we have a result right before us, a result we have ourselves produced, and we still do not understand it. Our cognitive schemata form a cloud between 'us' and the material we are thinking about" (Noddings, 1984, p.60).

On the other hand, when I feel the unease in knowing that caring is <u>not</u> happening there is a tendency to scurry for my list which illustrates for the student "caring about" behaviours. When questions arise, I seek confirmation through objective means. The professional context in which clinical nursing instructors work demands an external validation of their inner perceptions of students' practice through the provision of objective data. We validate caring as the actual work of nursing practice, a likening to Morse's conceptualization of "caring as a therapeutic intervention". That perspective provides the frame of reference with which we then evaluate students.

The preoccupying notion that all evaluation must remain objective is evident in the suggestions by Lenburg (1979) who proposed "performance evaluation criteria" to "test" students in their clinical practice. "To be fair the test must be uniform, and equivalent for all students and judged by the same criteria by all of the faculty involved" (p.2). The development of such criteria and these "testing situations" arose as a result of instructors feeling much discomfort with the thought that their not so objective impressions were playing too large a role in their clinical evaluations. The underlying premise is that to include the 'subjectivity' of the instructor would render the evaluation biased, untrustworthy, unfair and generally of little worth. Subjectivity is given to mean "an orientation to the object of study (nursing, caring, student, patient) in a unique and personal way" (VanManen, 1990, p.20). Indeed confidence is rarely placed in a knowing which is formed "in a unique and personal way" and not substantiated with objective, concrete, empirical evidence. The establishment of strict standards, criteria and itemized lists sets up expectations for how all evaluation must be done in judging the worth of a student's performance. There is little room for the instructor's perceptions, experience, intuitive

understandings and impressions to be brought to bear on these evaluations. In other words, the instructor's own constructions of reality are not given a legitimate avenue to impact on her practice of accounting for her students' caring practice.

Bevis (Bevis & Watson, 1989) has written that:

> Evaluation of student learning is the way teachers and learners find a landmark or point of reference. Evaluation provides indicators, clues, cues, signs and signals that tell both teachers and students where they are in relation to where they want to be...(p.262).

Bevis' definition of evaluation would indicate a need to discern where the nursing student is in comparison to some guideline or expectation about where they might be going. How do nursing instructors make sense of the student's nursing practice? How do they get in touch with where the student is? There are a variety of ways and means that the teacher will use to gain access to the student's practice and understanding of their practice. Some students abhor it when they finish with a patient, jubilant in their independence, to part the screening curtains and discover an instructor, lurking and listening. I know because as an instructor, I have been discovered lurking. I feel like the ugly detective, skulking about, collecting evidence to provide myself with a more comprehensive picture of my student's practice.

How else do I, the clinical nursing instructor, discern where the student is in relation to where we would like them to be? I watch from a distance; I observe close at hand; I ask questions and listen to responses; I talk to patients and I talk to staff nurses; I read student journals, or care plans or progress notes; I spend time with each student and try to ascertain who seems to require guidance.

Some aspects of clinical nursing evaluation are rather straight-forward and easily evaluated while others are less easy to discern. I observe the student swabbing the top of the multi-dose vial, she injects air into the vial, she draws back, we check the dose together. It is correct. Fine. This student knows how to prepare an injection and it is comparatively easy to evaluate from a behavioral objective way of knowing. There are other occasions when a student's nursing practice is less easily evaluated. For example, another student may shake uncontrollably when doing the same procedure. Anxiety will often cloud students' ability to perform technical skills. In this instance I might use humour to dispel the nervousness which obscures and confuses the otherwise well-prepared student. The relationship between the teacher and the student will have a bearing on how well the instructor can see through and allay that veil of

anxiety to more adequately evaluate the student's practice.

Instructors do not always look on from an objective distance but evaluate students within the context of their relationship, situatedness and experience. It was useful to explore multiple ways of knowing to understand how something other than objective data might help instructors make sense of their students' practice.

Multiple Ways of Knowing

> If caring is a way of being in the world that we value above other ways, the situation is serious in the extreme. More vigorous caring will accomplish nothing. We have to develop other ways of knowing (Gadow, 1990, p.3).

As early as 1978, Carper was researching and writing about ways or patterns of knowing in nursing. She identified four fundamental patterns of knowing which were held to be of most value in the discipline of nursing (Carper, 1978). At the outset of her discussion she identified the <u>empirics or science</u> of nursing. Nursing, when viewed as a science, is involved in the development of a body of knowledge which systematically describes, organizes, categorizes and predicts phenomena of interest to nursing. The aim is to provide abstract and theoretical principles which will guide nursing practice. The knowledge obtained

through research in nursing (as a science) is "empirical, factual, objectively descriptive and generalizable" (p.16). Carper acknowledges that many would argue scientific nursing knowledge is the only valid and reliable knowledge and consequently only that worth pursuing. "There seems to be a self-conscious reluctance to extend the term knowledge to include those aspects of knowing in nursing that are not the result of empirical investigation" (p.16).

A second pattern identified by Carper is the moral component of knowing in nursing. She suggests the moral component is not simply being able to interpret the code of ethics for nurses. It is involved in the complex web of choices, for both patients and nurses surrounding a person's health and well-being. The moral component of knowing in nursing is essential to the practice of nursing to deal with care delivered in real concrete, specific situations. The ability to look carefully at the wholeness of a situation and consider the rightness or wrongness of actions, obligations, and philosophical orientations is a reality for practising nurses and will continue to assume a more predominant place in nursing practice (Leininger, 1989).

The final two patterns identified by Carper (1978) are also of interest to this research. They are the

aesthetic and personal knowing patterns. Aesthetic knowledge is different from that experienced in science in several important aspects. Art "involves the creation and/or appreciation of a singular, particular, subjective expression...(and)...it remains specific and unique rather than exemplary" (p. 16). Nursing, as an aesthetic way of knowing requires nurses to pay attention to the particularity and the uniqueness of individuals. It requires what Dewey refers to as the difference between recognition and perception (Dewey, cited in Carper, 1978). Recognition serves to identify. Perception goes beyond identification and "includes an active gathering together of details and scattered particulars to form an experienced whole for the purpose of seeing what is there" (p.16). Carper credits experienced nurses with the ability to conceive of the whole person. Using Langer as the source to articulate her thoughts about the "design" of nursing care, she claims, "the design, if it is to be aesthetic, must be controlled by the perception of the balance, rhythm, proportion and unity of what is done in relation to the dynamic integration and articulation of the whole" (Langer, cited in Carper, 1978, p.18). Benner (1984) has described the "expert nurse" in similar form. An "expert" will grasp the total situation or problem with "perceptual certainty"

(p.32), while the less experienced nurse will need to rely on a collection of maxims, rules and rationales to feel confident in her conclusions.

Carper suggests that the capacity to empathize is an important "mode" in the aesthetic pattern of knowing. To participate in, or vicariously experience another's feelings opens the nurse to the possibilities of the reality of another. With this openness to possibilities a larger repertoire of choices in nursing care becomes available.

The other pattern of knowing described by Carper is personal knowing. It becomes the most problematic for Carper to describe but also one she feels essential to understanding nursing as an interpersonal process. There is growing awareness of the "therapeutic use of self" in nurse - patient relationships documented in nursing literature (Benner, 1984). Personal knowing is the kind that "promotes wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment..." (Carper, 1978, p.20). Diemort Moch (1990) has further developed the concept of personal knowing and has identified these three components: (p.156)

1) Experiential knowing - becoming aware through participation or being in the world.

2) Interpersonal knowing - increased awareness

through intense interaction or being - with the other.

3) Intuitive knowing - immediately knowing something without use of reason.

Through personal knowing we honour the distinct flavour of two persons coming together in Buber's "I - Thou encounter" (Buber, 1979). The relationship is approached with authenticity and integrity. Buber speaks of a "sacrifice of form" which precludes categories, classifications and predetermined expectations. There is greater willingness to accept vagueness and ambiguity.

Carper's suggestions of an expanded view of nurses ways of knowing have aided my own thinking about other ways of knowing in nursing education and particularly in the clinical forum. The categories of the moral, esthetic and personal patterns are well aligned with my beginning assumptions because they pay attention to aspects of the uniqueness and the wholeness of the human encounter; the knowing evolving out of relationship; and knowing as a quest for understanding rather than explanation. The search for explanation is better served by the empirics or science of nursing. As an experienced nurse I can appreciate that all of these patterns play a role in my encounters with student nurses. Most instructors of nursing arrive

with a rich and varied background in nursing practice before attending to the education of nursing students. It seems reasonable to me that these patterns will find a place in our relationships, modes and ways of being with our students.

Another research work that is influential to this discussion is a phenomenological study by Belenky, Clinchy, Goldberger and Tarule (1986). They studied the way women think, learn, develop, and give sense and meaning to their world. The authors identify seven orientations to ways of knowing: silence; received knowledge: listening to the voice of others; subjective knowledge: the inner voice; subjective knowledge: the quest for self; procedural knowledge: the voice of reason; procedural knowledge: separate and connected knowing; and constructed knowledge: integrating the voices. The authors employed the metaphor of 'voice' and used it as a unifying theme to describe the intellectual and ethical development of women.

Two of the orientations listed above are pertinent to this research; <u>procedural knowledge</u> and <u>constructed knowledge</u>. Procedural knowledge is further divided into two sub-categories, separate and connected knowing. Borrowing Gilligan's (1982) terms, Belenky et al enhance the meanings. "When we speak of separate and

connected knowing we refer not to any sort of relationship between the self and another person but with relationship between knowers and the objects (or subjects) of knowing (which may or may not be persons)" (p.102). Separate knowers adopt impersonal and objective procedures for acquiring knowledge. "To be objective, here, means to speak dispassionately, to exclude your own concerns and to adopt a perspective that your adversaries may respect ...It also means to exclude *all* feelings, including those of the adversary, examining the issue from a strictly pragmatic, strategic point of view" (p.109). The reader might be reminded of an earlier discussion quoting Lenburg's (1979) suggestions for clinical evaluation. "To be fair the test must be uniform, and equivalent for all students and judged by the same criteria by all of the faculty involved" (p.2). Lenburg's suggestions find a close similarity to separate knowing.

Connected knowers develop means for tapping into other people's knowledge, primarily through empathy and acceptance of others' experiences as a way to acquiring an understanding. Note that this way of knowing is oriented to themes of understanding rather than to themes of knowledge, alike to the earlier distinctions between human science and natural science. "Understanding involves intimacy and equality between

self and object, while knowledge implies separation from the object and mastery over it. Understanding... entails acceptance" (Belenky et al, 1989, p.101). Connected knowers will develop a particular sort of relationship with the object of inquiry in their quest for understanding and the truth will be created for them in the process of that interaction.

For Belenky et al (1989) all procedural knowers are "objective, in the sense of being oriented away from the self - the knower - and towards the object the knower seeks to analyze or understand" (p.123). Connected knowers look at the views held by others through the others' terms, not on their own terms. Belenky et al (1989) described an orientation which went beyond procedural knowledge to a voice which integrated separate and connected knowing. They chose to label this orientation "constructed knowing." It is a way of knowing which is "an effort to reclaim the self by attempting to integrate knowledge that they (the constructivist knowers) felt was personally important with knowledge they had learned from others" (p.134). A constructivist knower becomes willing to listen to their own voice integrated with the voices of others.

Do clinical instructors transform their understanding by listening to their own voice

integrated with the voice of others when they evaluate their students' caring? As mentioned, in informal discussion with instructors I heard cues which alerted me to the nagging tension caused when those inner voices, or personal constructions of reality about students were not given a means of expression in the formal context of evaluation. I suspected that more experienced instructors found a means of resolving this tension by transforming their subjective thoughts into objective "data". There is acknowledgement by nursing instructors that clinical evaluations pose ongoing problems with no satisfying solutions though many have been developed and implemented. One author identifies clinical evaluation as "...this mysterious area of nursing education" (Woolley, 1977, p.308). In the same paper analyzing the history of clinical evaluation she claims, "Small wonder that educators so frequently work out their own solutions, and that their evaluations are so often subjective" (p.308).

Bevis (1989) speaks of a similar pattern of evaluating:

> Even when using behavioral objectives as starting points for criteria for clinical evaluations, expert teachers use their perceptual awareness and educational judgment to perceive a gestalt, to attend to a gut feeling, and then to seek evidence to substantiate what they know to be true (p.280).

The research of Belenky et al (1989) takes this

process a step further and acknowledges outright the integration of separate and connected knowing to create a constructed knowing. Acknowledgement of this integrated, constructed knowing would perhaps be more honest than couching the instructor's "discerned reality" behind the language of a rational empiricist perspective.

This chapter has explored aspects of clinical evaluation with particular emphasis on discerning caring in students' practice. Objective data, while helpful in evaluation practices, seemed somewhat incomplete for understanding how the relationships, situatedness and experiences of nursing instructors might influence their evaluations. Possibilities for evaluation are presented by acknowledging that other ways of knowing and understanding do find their way into evaluation practices. Two research studies on ways of knowing were examined and some aspects of these two studies found a close fit and therefore lend support to my initial assumptions outlined in chapter one. With that orientation to the question presented I will discuss the methodology adopted to create an understanding of the question raised: How do clinical nursing instructors evaluate caring?

CHAPTER FOUR

SEARCHING FOR UNDERSTANDING: METHODOLOGICAL CONSIDERATIONS

Methodology must remain true to the ends in view. Because the search for understanding motivated this endeavour, the inquiry was best served by a hermeneutic approach. Ricoueur said that hermeneutics is "...the process by which we come to know something of mental life through the perceptible signs which manifest it," and that "...interpretation is the art of understanding applied to that manifestation" (Ricoueur, 1981, p. 150).

Problems to construction an understanding were three-fold. The first was to find a means of drawing out from "participants" (Morse, 1991; Campbell & Bunting, 1991) those experiences which would offer references to multiple ways of knowing in clinical evaluation. The second was to detect and interpret the perceptible signs in the experiences. The third is to give life again to those experiences in the written form to engage the reader in the dialogue.

The Participants

I decided that conversational interviews would offer the best means to access the experiences of clinical nursing instructors. As the nature of the

research required a thoughtful and extensive exploration of the topic, and interviews were rather lengthy, I interviewed four clinical nursing instructors. The pseudonyms of Ruth, Robin, Clare and Barbara were chosen by the participants to preserve anonymity. The participants were chosen on the basis of clinical teaching experience (three years or more), an orientation to nursing which valued notions about caring and knowing, an ability to articulate thoughtfully, and interest in being involved in this research. The participants ranged in age from 35 to 51 years; all had extensive clinical experience in nursing prior to becoming nursing instructors and three of the participants had taught in more than one nursing school. Two participants had completed graduate level education, one was in process of completing a masters degree and the fourth participant was seriously considering beginning a masters program. Most significantly, all of the participants were more than acquainted with the question as they had each pondered it in a variety of ways prior to my question being raised in a formal sense. Clare actually thanked me for inviting her to talk about what had been "...part of my struggle...I guess for many years...maybe 50". She laughed at herself for saying so but part of my delight and revelation in speaking to these thoughtful

educators was that they embraced my question in such a way that it became their own. And in their understanding and interpretation of my original question the conversations merged into other queries in their work as educators and nurses committed to the practice and profession of nursing. One inquiry which predominated the discussion was the paradigm shift occurring in nursing education which I discussed in chapter one.

All of my participants are involved in the paradigm shift occurring in nursing education as they are teaching in a program which is adopting a new curriculum committed to embracing caring as the primary orientation to nursing practice. This factor is important to consider because they were each grappling with the need for a transformation in their own educative practices from a behavioral paradigm to this new curriculum. At the time of the interviews no participant was teaching in the new curriculum but they were all making attempts to become informed and undertake some of the ideas of the "new" curriculum. However, committment to the old curriculum constrained those attempts somewhat as the program continued to employ behavioral objectives to clinically evaluate students. These objectives cover such aspects as the nursing process, application of theory, skill

acquisition, communication patterns, incorporating teaching into nursing practice, and acknowledgment of family and significant others. All of these aspects of nursing practice are evaluated against specific standards of behaviour. The questions I had raised invited participants to not only comment on how they evaluated caring presently but also to step outside of that behavioral context and think about how evaluation might look in the new curriculum. The invitation was greeted with enthusiasm and I suspect that response was elicited because nurses inherently know or learn that not all of the important aspects of nursing can be attended to within a behavioral evaluation framework. More specifically, caring was not explicitly stated in the objectives and by that exclusion caring is de-valued as a significant feature of nursing practice. Ruth and I spoke about this lack of attention to caring in the behavioral objectives. "We don't asses caring...anywhere...we have our eight objectives which are very specific about the nursing process, the communication and the theory and I guess part of caring might be touched on in our objective about communication skills and working with families but it is not labelled as caring....(your) question about How do you assess caring? I thought was an absolutely reasonable question".

I contacted my four participants by phone and without exception each agreed enthusiastically to share their stories and reflections with me. A letter of introduction to the research (see Appendix A), a consent form (see Appendix B) and a copy of my research proposal were sent to each participants. The consent form was signed by each participant which outlined the preservation of confidentiality, withdrawl from the research, and the intent to destroy tapes and transcripts. I requested that they read my proposal to open them to my text and invite them to engage in the dialogue I had already begun. As mentioned, these experienced educators had already grappled with the question in their own reflective practice but the exercise of reading my proposal was helpful in preparing the participants to talk about their own experiences given the orientation to the question that I had proposed. This proposed orientation finds a compatible harmony with the new curriculum.

A Conversation: Not an Interview

I adopted Mischler's (1986) attitude towards the interview. He views an interview as a "speech event", a discourse between speakers whereby meaning is constructed through their interaction. He has suggested that more traditional views of research interviewing

have placed a hierarchical power structure on the interviewer-respondent relationship which impinges and constrains the very purpose of coming together, to construct meaning out of life experiences. In every day conversation we ask questions, receive answers, and arrive at shared understandings on the nature of these exchanges with our families, friends and colleagues. With the formal interview "shared understandings, common knowledge and reciprocal aims of speakers" (Lazarsfeld, cited in Mischler, 1986, p. 1) are often lost due to a variety of problems in the questions, answers, speakers and analysis of those events. Mischler's approach to the interview construes it more as a conversation between two people which is guided by norms of appropriateness and relevance within the common language of the interacting parties. Mischler's suggestions seek to do away with the interview which causes decontextualization through a behavioral stimulus-response tradition of question and answer. Mischler invites story-telling as a means of setting the dialogue in context, allowing the speakers to find their own voice and to control the introduction and flow of topics. Rules of conversation were applied (Labov and Fanshel, cited in Mischler, p.74). As with social exchanges, you recognize when a "story" is being told and allow the other to talk more than the usual

"turn". A good listener will seek clarification and insight in the speaker's disclosures. The listener would also encourage not only the dialogue but the joint construction and understanding of the meanings embedded in the story.

Early in my research I had attempted a trial interview which did not include specific questions and that conversation was not especially effective, nor did it offer my participant any guide to discussion. After that initial experience I asked the participants to consider the following questions to provide a loose framework or starting point for our conversation.

1. What does "caring" in nursing mean to you?
2. Can you describe an occasion which exemplified a student caring? What led you to this conclusion?
3. How did this occasion impact on your evaluation of your student?
4. Can you describe an occasion in which you felt the student was <u>not</u> caring? What led you to this conclusion?
5. How did this occasion impact on your evaluation of your student?

The purpose of posing these particular questions was to help advance the primary question: How do clinical nursing instructors evaluate the caring of their students? I did not intend to conduct a linear

interview finishing one question and moving steadfastly to the next. These five questions were posed as a way of offering some structure or focus for the participants. I found it to be quite effective for orienting the participants. Throughout the interviews we were able to leave the questions behind to explore particular meanings further. The specific questions and answers often were concealed in the dialogue. If the conversation seemed to wander too far from the topic at hand, the questions were available to focus the discussion. The first question entails reflection on meanings of caring. By asking participants to reflect on meanings of caring we were more able to understand how that personal meaning might impact on instructor's evaluation practices. As previously asserted I believe most experienced nurses do construct personal meanings of caring though they may not be able to immediately articulate that meaning.

The four remaining questions request specific incidents and helped to orient the conversations to the matter of evaluation. These questions helped us to focus on specific incidents, stories and anecdotes that instructors could share about evaluating students.

All of the participants stated that they found it very helpful to read my proposal and emphasized the introductory anecdote as an excellent means of inviting

them to share their stories with me. One instructor said that the story set my text and the theoretical writings in context with her own nursing education project and assisted her in drawing connections between her meaning(s) of caring and the bearing that had on evaluation.

All of the conversations were taped and transcribed. Transcriptions and any identifying reference to participants were destroyed following the interpretation. The conversations ranged from two to three hours. My experience was that after two hours both of us were quite fatigued and a comfortable silence often indicated preference for closure of the conversation.

Interpretation and Understanding

Interpretation of the text became the next methodological consideration. The intent, we remember, is the search for an understanding as opposed to an explanation. Several writers in hermeneutics informed my thoughts on notions about understanding. Ricouer (1981) clarifies why understanding is distinct from explanation in the human sciences.

> For in natural knowledge, man grasps only phenomena distinct from himself, the fundamental 'thingness' of which escapes him. In the human order, on the other hand, man knows man; however

> alien another man may be to us, he is not alien in the sense of an unknowable physical thing. The difference of status between natural things and the mind dictates the difference of status between explanation and understanding (p.49).

Emilio Betti wrote that "...we may tentatively characterize interpretation as the procedure that aims for, and results in, Understanding [sic]. Interpreting, in view of its task, is to bring something to the Understanding [sic]" (Betti, cited in Bleicher, 1978, p.56). Understanding, Betti writes, is the reconstruction of the meaning of what is said to us within the contours of the way that we think. "...the interpreter is called upon to reconstruct a thought and recreate it from within himself [sic] making it his [sic] own..." (p.57).

Gadamer explains that understanding "transcends" the wording of what is said so that we may actually "apprehend" what is said to us. For Gadamer interpretation is a "pointing to" something as well as a "pointing out" the meaning of something (Gadamer, cited in VanManen, 1990, p.26).

Ricoueur believes that the intended message of the author or participant is one mission of hermeneutics. "What must be reached is the subjectivity of the one who speaks, the language being forgotten" (p.47). Ricoueur (1981) goes further however. "If we can no longer define hermeneutics in terms of the search for

the psychological intentions of another person which are concealed behind the text, and if we do not want to reduce interpretation to the dismantling of structures, then what remains to be interpreted?" (p. 141).

Ricoueur sees the process of interpretation as "...exposing ourselves to the text and receiving from it an enlarged self..." (Ricoueur, 1981, p.143). Interpretation therefore is not so much an explanation of what is hidden beneath the text, but what might be made possible in the revealing of the text. He opens for us a world of possibilities. "For what must be interpreted in a text is a proposed world which I could inhabit and wherein I could project one of my ownmost possibilities" (p.142) and "...I find myself only by losing myself" (p.144). This openness to the interaction of self with the participants and their text attracted me to the way Ricoueur discusses hermeneutics because it appeals to my thoughts on the construction of truth. There is a relationship between the knower and the known in that the knower is the vessel through which truth is constructed. And further that truth will be modified and changed in the process of interaction, opening up new possibilities. The reader may acknowledge in Chapter 5 that the relationship between the participants and I was helpful for delving into, and probing sensitively to articulate

their meanings and experiences of caring. As mentioned earlier, I intended to remain open to my participants' text so that a reconstruction of meaning could ensue, and that the possibilities of meanings had an opportunity to transcend my ways of thinking.

Van Manen (1990) has suggested that the researcher might return the interpretation to the participants to confirm that the interpretation is what the speaker intended to say. I did not however, and considered the participant's text intact following our conversation. Ricouer (1981) has written about the "autonomy of the text" as a way of liberating or emancipating the author, or in this situation my participants. "The autonomy of the text already contains the possibility that what Gadamer calls the 'matter' of the text may escape from the finite intentional horizon of its author; in other words, thanks to writing, the 'world' of the text may explode the world of the author" (p.139). In keeping with Ricouer's ideas of opening the self (myself) to possibilities of being, I felt that returning my interpretation to the participants for confirmation might again modify my emerging interpretation. The interpretation is a fusion of possibilities as there were four participants. I wanted to construct an understanding out of these interactions through not only the integration of the

participants' thoughts but a willingness to listen to my own voice as the interpreter.

There were multiple possibilities in understanding revealed by the transcribed discourse between myself and the participants. The thrust for my interpretation is not to state unequivocally that this is the correct or right interpretation but that this interpretation is the best one, a claim which relies on the persuasiveness of my text. As mentioned at the outset of this discussion on methodology, the third problem to the construction of understanding is to write in such a manner that the reader of the thesis can enter into the dialogue. I have described examples taken from the conversations with participants and my own thoughtful reflection about those conversations. Transcriptions are included to support my interpretation. I was cautious not to succumb to higher levels of abstraction or conceptualization but to preserve the text in real life experience via anecdote and story.

In summary, this chapter has outlined the major methodological considerations for this study. As the search for understanding lies at the heart of the research, a hermeneutic approach seemed best suited to answer the question. While several scholars in hermeneutics have informed the work of this project, Ricoueur's writings are the most appealing because they

align with my thoughts on the constructions of truth. That is to say, the relationship between the knower and the known is ultimately necessary and through the knower "truth" is constructed. The following chapter offers the participants' perspective on meanings of caring disclosed in the conversations. Their definitions and stories form the backbone of the interpretation to inform the emerging understanding of how clinical nursing instructors evaluate the caring of students in nursing practice.

CHAPTER FIVE

CONSTRUCTING UNDERSTANDING

This chapter will focus on the conversations with participants and understandings arising from those conversations. While each instructor had difficulty describing what caring means to them conceptually, every participant early in the conversation offered me a story which served to explicitly or implicitly expose their meanings of caring. I think the reader will agree that these stories are highly effective. I highlighted in the previous chapter how instructors' meanings of caring are relevant to the discussion because it is these meanings which provide the touchstone with which instructors may evaluate their students. Three themes of caring emerge from the participants stories: being involved, touch and time. As I was cautious not to succumb to higher levels of abstraction or conceptualization I remind the reader (and myself) that while these themes are possible characteristics of caring they are always set against the particular and unique context and situatedness of the story. Following the discussion of the meanings of caring the writing more specifically focuses on the evaluation of caring.

The Conversations

At each interview I began by asking each participant how they understood my thesis question "How do clinical instructors evaluate caring." My inquiry to them was based on the assumption that all participants had read my proposal as I had requested. One participant focused not only on my question but the intent of my question; another participant's understanding was that I was exploring nurses' caring behaviour while the third participant said that I was attempting to broaden our minds to think of nursing and caring from something other than a scientific paradigm. The fourth participant thought I was asking about how nurses define caring. It was so interesting that each participant related to my question in a different way. I suspect that the differences were dependent on their education, their own meanings of caring and how they each understood evaluation. I then asked whether mine was a reasonable question to ask. They each offered a resounding affirmative and three of the four related that not only was the question reasonable but it had to be asked given the educational paradigm shift to the new 'caring' curriculum. They all attended seriously to the question recognizing that the evaluation of caring had not been well understood to date in nursing education. Ruth responded, "...reflecting back

...after I read your paper....we don't assess caring anywhere..." Robin said, "Yes, it is a question that has to be asked because I don't think that we do (evaluate caring)". And of course I mentioned Clare's response earlier who laughingly said that my question had been part of her struggle for many years. Barbara also agreed that it was a good question because "...unfortunately some of this stuff is not concrete, it is a feeling and it is hard to measure...". It was reaffirming to hear that my participants shared a concern about evaluating caring in nursing education.

Constructing Meanings of Caring

The participants' enthusiasm and attentiveness to my question highlighted how significant they considered caring to be in nursing. There was never doubt raised that caring should be of utmost importance to the practice and therefore to the education of nurses. That premise was acceptable to all of the participants. Caring was automatically assumed to be the most important element of nursing. I would emphasize that all participants are involved in a shift in nursing education to one which declares caring as the guiding framework. My experience with nurse educators adopting the "caring" curriculum has been that they enthusiastically embrace these seemingly new ideas in

education. While not fully understanding what such a shift would mean, nurse educators fully endorse the whole notion of an education for nurses grounded in caring. I think this paradigm shift is often accompanied by a huge sigh of relief that we are finally coming to our senses by "...reclaiming our philosophical roots" (Hills, 1993).

Requesting a conversation about evaluating caring was a useful opportunity for participants to continue the dialogue about their current educational practices as well as potential practices for the future. While not fully attending to it myself at the time I realized in the rereading of transcripts that my participants were in a state of flux created by moving from one paradigm to another. Discomfort was experienced because some loyalty remained intact for the old paradigm but for the most part there was endorsement for the not yet fully formed curriculum. It is important for instructors to realize that some of their current practices are in harmony with the new curriculum.

My conversations with instructors confirmed my earlier assumptions that caring is a highly personal concept. Although informed by theoretical views found in the literature on caring, these nurse grounded their concepts and meanings of caring in the experiences and

reactions to experiences that they had encountered in their lives as nurses and people living in the world with others. Participants and I wiped away tears as they related stories which celebrated caring or exposed a distinct lack of caring. This outward show of emotion expressed the profound contextual understanding and commitment we shared for caring in nursing.

Not only did the instructors state outright that we don't evaluate caring in this present curriculum, but it becomes more apparent listening to or reading these wonderful stories of caring. These exemplary stories reveal the essence of caring in nursing and it becomes apparent from the rich texture of the stories that a behaviourial objective framework is inadequate by its very nature for capturing the experience of caring in wholeness. A behavioral objective methodology depends on reductionism rather than holism and caring experiences seem lost in a reductionist framework.

When I asked my participants "What does caring in nursing look like to you?" or "What is caring?", the answers were often halting and tentative. I sensed that these individuals all felt the question very significant which called them to think carefully and thoughtfully about their response. Once begun however there was an eagerness to enhance, a desire to get it

right, and an earnestness to explain in a manner that we could both understand. Barbara clarifies in the following excerpt. I have asked her how she recognizes caring.

> *....well it's the things that they...not necessarily measurable things... but they go the extra mile...they don't do it because I am there...the one...stands out..the students that just do it because an instructor is there watching them...you know that they, that as soon as you are not watching them you wonder whether they really believe this or whether they are just doing this because you just happen to be there at that particular time...the students that really strongly believe in demonstrating caring abilities go the extra mile..they do things that are not necessarily objective or measurable...but they are the ones that spend the extra time rather than going for their coffee break ...that stay overtime just to comfort somebody that needs extra comfort they (um) fluff the pillow and turn it over and give them clean sheets even though they've already done it once today and they don't really need to be changed but they know that this person will be a little more comfortable if they do that ...they just... there is just a sense...a feeling like....after you have been in education for a long time...within a very short time you know which ones are really...that really have those qualities...and which ones are just doing it...and maybe don't really internalize it...maybe I could share another example with you...*

These answers often seemed incomplete; thoughts were not completely finished before moving on to the next in an effort to help me understand. There seemed a sense of urgency to comprehensively answer the question: What does caring in nursing mean to you? Words became inadequate without the embeddedness of a remembered experience of caring. The participants

returned to stories time and again to help us understand what caring means. Gadow (1990) writes about the value of story to communicate meaning.

> Participation in vulnerability, one's own and another's and attempts to alleviate it, are experiences. They are encountered in only one way, living in the country that is nursing. They are communicated in only one way, in personal accounts of exploration, in narrative, poem, dreaming, song,-- in other words, story... (Knowing and caring) are rendered as one in story, because story is like gesture and unlike science, in that all of its meaning is contained within it; it is both expression and meaning. It is offered on the basis of intersubjectivity, recognition that another will comprehend the meaning (p.14).

Stories became the vehicle which participants used to offer me access to their meanings of caring. I listened and was enraptured as my participants explored their meanings of caring mediated through their experiences of witnessing caring.

Gadow again: "Story is the form that truth takes, and exploration the form that inquiry takes" (1990, p.13). I had invited these educators to discuss caring in nursing education with me and it became quickly evident that their meanings of caring originated and were further informed by their past situatedness in their own nursing practice as well as their personal lives outside of nursing. Three participants chose to include their encounters with nurses when they were not in the role of 'nurse' at the time. They reflected on times when they were either a patient or significantly

associated with a patient. I can relate to these understandings because my own meanings of caring in nursing evolved not only from my life as a critical care nurse, but also from being a friend to my neighbour with a chronically ill husband, the aunt of my critically injured niece, and the daughter of my dying father... We develop our understanding of the experience of caring in a world lived with others. We do not understand caring simply from theoretical frames of reference, but through experiences which are "embedded in personal and cultural meanings and commitments" (Benner, 1984, p. 171).

The stories participants shared with me were rich in description, bound to the particularity and the uniqueness of the situation and often included an ethical deliberation. Bevis (Bevis & Watson, 1989) describes *rendering* as a way of describing the ineffable. "In education , critics must render a situation in language that is not language to begin with but experience and reactions to experience. The language used for this must be the qualitative language of metaphor, simile, analogy, and allegory. It is not evaluative but evocative and therefore is powerful in its ability to communicate in thick rich imagery" (p.290). Barbara continues.

> *...maybe I could share another example with you...It was actually a student I had...She (the*

student) had a lady who was terminally ill. She and her husband had retired and she was in the end stages of leukaemia. Both she and her husband were in denial about the seriousness of the disease...she had always had remissions before and was sure she was going to have a remission again and she was going to get better and go home again. But the reality was that this time it was a lot more serious and they weren't able to give her the kinds of treatment that she'd had before because they kind of used up everything that was at their disposal and now there wasn't very much left that they could do for this lady in terms of medical intervention. This student spent a lot of time with this couple and through the process of spending time with them discovered that they had travelled extensively in their life, he had been an engineer and they had lived all over the world. But they had always been in sort of high paying society type jobs and had been, as a result, quite authoritarian and used to people doing what they wanted rather than doing what other people wanted. They only had one daughter and years and years before they became estranged from her because they wanted her to marry this person that they had picked out for her that apparently was from the same society that they had always lived in. But the daughter had fallen in love with someone that they didn't view as being acceptable. In the end she decided to marry this fellow and the couple no longer had anything to do with her...and here the mother was at the terminal stage of her life estranged from her only daughter and still they wouldn't get beyond their anger at their daughter in order to spend some time with their daughter before their mother died. The student literally spent hours and hours with this couple, and with the gentleman on his own and in the process was able to get them to realize that the mother probably was not going to go out of the hospital this time...

Barbara went on to describe how her student had fostered the reconciliation of mother with daughter before their final parting.

Barbara's deft use of her "example", the relationships inherent within, and the association that

we, the listeners, make with the vulnerability of the human condition, is far more persuasive than "they are the ones who spend the extra time rather than going for coffee". Like Barbara, the other instructors provided the detailed context to frame their caring stories.

Nursing (and caring) does not occur in isolation of context but happens within it, or as Gadow would say "in the country that is nursing" (1990, p.13). Consider the following statement by Corless and Riordan (1990) speaking about the patient context. "The client is influenced by the inpatient/outpatient level of technology and environment for care, the nursing system, and personal and familial resources" (p.54). Now contrast(ed) with "...and here the mother was at the terminal stage of her life estranged from her only daughter and still they wouldn't get beyond their anger at their daughter..."

Gadow (1990) claims that the dualism of subject - object which pervades the generation of knowledge in nursing cannot begin to understand caring because we distance ourselves from what we are inquiring about. "In dualism, knowledge precedes caring and therefore precludes it. In life, lived as involvement, caring precedes knowledge" (p.13).

Caring as Involvement

These educators spoke the involved language of

nursing practice. I did not just hear about the cancer patient in 306B but learned a little of her life, her work, and her disposition. I was introduced to her family members and became privy to their worries. This desire to understand and appreciate the broader context impacting on a patient is the involved language of caring nurses. These nurses recognize their patients' situatedness in lives lived outside the health care setting and their integral connection to significant others. Caring nurses are attentive to the particularities and the uniqueness of their patients. One instructor stated that there must be "recognition of the person outside of the hospital experience".

Robin provides this story to ponder involvement in nursing.

> *I've got...a student right now working paediatrics.... and she was working with this young girl, this little eleven year old girl and part of her...you know you have to know her history... She was going to be in for six weeks. She comes in and she's just...foul mouthed and just a horrid kid in a four bed room and she doesn't want to be with the "bloody Punjabs" and all this sort of thing...what we find out is..she's been sexually abused by uncles and dad...she lives in the household with uncle and dad and all this sort of stuff. In the six weeks she's been in hospital, which is a safe place, she's just...just a <u>wonderful</u> person, she's the sweetest little girl. Then as we are preparing for her to be going home, between child life, social workers, the nurses...they were all trying to get the social workers from (her community)... to come down to see this girl in this environment...but through the lack of resources, time, money whatever, of course they can't let a case worker off for the day to come down (here) just to look*

at a kid...so they don't really know her. And I said to the students, you know it's sad but just watch...just watch for any behaviour changes that might happen...and it was amazing starting the day before she was going to go home, she started to become very insular...in her language she started to become very foul mouthed again with patients... even her roommates, with other RN's. I think it was almost that she was having to start to build up her walls again because she knew she was going to go home...and the one student who had really been caring for her a long time, and had really responded well with her was devastated seeing how this girl was having to re-protect herself before going home to this awful environment. What should we be doing (she asked), we should be doing more..But our inability to do any more than what we could do was that was really painful to that student.....

She came up to me yesterday and she was all excited and she showed me a letter. She had given this girl her name and address to say that even though you are far away I could be someone you could write to for support and to know that I am there to help you...but you can't come and live with me ...you can't... that wasn't the expectation of giving the name and address but it's that I could be a friend that you could write to... so she got a letter yesterday and she was so excited about that. To me that was real caring...and yet, then other instructors say...is that reasonable?... and why would it not be reasonable?... but to me reasonableness isn't an issue. Yeah, well what's the big deal?...so you give an 11 year old kid your name and number or similar sort of thing...if you would like to write just, to be a friend or whatever here it is...so she wrote back. And you know in the student's letter she put some stickers in and little things that she was thinking would be appropriate to let an 11 year old know that she had thought about her...and I just think that's really caring...whether it's reasonable...whether it's necessary or not I don't know if that matters...to me though it's just an example of caring because there is a lot of people who came in contact (with the girl) and a lot of people in their day to day job could have written a letter back...that someone had taken five minutes to do something special. And so that I think is real caring.

There is a maxim in nursing which reminds nurses not to get "attached to" or "too involved" with patients (Morse, Solberg, Neander, Botoroff, Johnson, 1990). Robin derides this notion by wondering out loud what harm could come of it. The student offered...the little girl responded...the student was touched...the relationship was authentic...Being "reason-able" does not enter into the debate for Robin.

Ruth and I also explored notions about becoming too involved with patients. On one occasion she was teaching a nursing theory class about caring for the self and was quite surprised to learn that the entire class of students had received the message that nurses were not supposed to become so involved that they would express emotion. Specifically, nurses were not supposed to cry. "It was the whole class...they weren't supposed to cry...they were supposed to be strong..." Ruth and I could not remember ever being told not to cry but we both agreed that we had received the same message in our own nursing careers. Barbara also speaks to this perception about becoming involved with patients.

You can't expect students to just divorce their emotions ....I've had students say to me that other instructors have told them that they are not allowed to cry ..and this just personally blows me away to be honest with you...I think that (while) your emotions can't affect you so much that you can't ...perform in a situation,... but when you are with somebody who is dying or emotionally overwrought and you are sharing all those emotions with them ..I think that if you hold yourself back and don't demonstrate any kind of emotion then you are really interfering with the development of the relationship because it's almost like you are setting yourself apart...and I encourage the student who cries.. I mean I usually take them and give them a big hug and tell them that ...what they are feeling is all right... they have developed a relationship with this person and to not feel some of those emotions when they finally lose them...I mean I don't think it is really being honest...

There is a tension created here when we consider that genuine involvement with the patient can sometimes elicit genuine tears, which are seen by some nurses and instructors as undesirable. The tension is enhanced when we hear stories like Robin's which define caring by the extent of the nurse's involvement in the patient's life when involvement may be regarded negatively by some.

Benner's (1984) comprehensive study of the knowledge embedded in clinical practice identified "the helping role" as one significant domain of nursing practice. She distinguished "the helping role" from "the therapeutic role" (p.163). The therapeutic role creates a "professional distance" between the patient and the helper. The nurses in her study

"...repeatedly described a committed, involved relationship...*I thought of him as my grandfather and I cared what was happening to him*" (p.164).

Robin neither demands or expects that level of commitment from her students but nor does she hinder the development of an authentic relationship between student and patient. For Robin, these are opportunities for caring to take advantage of, not from which to shelter yourself or your students. An expression which Robin referred to more than once for describing caring was "taking on the burden of others". When nurses get "too involved" they may "take on" some of the pain, suffering, vulnerability and hardships of others. It is also important to remember that caring nurses also have opportunities to participate in the joy and success of others. Robin's perspective would question how genuine caring can occur if we do not run the risk of being transformed by the experiences of others, or if we do not take advantage of the opportunities presented to us to become involved with our patients.

Caring as the Qualitative Touch

The stories also point to the quality of touch as another illustrative characteristic of caring. Robin states that touch can give you that "feeling of connectedness to the person". Ruth describes it as a

"form of laying your hands on another person as the indicator of the caring part." She recalls an occasion when she was a patient in hospital.

> *I was having a particularly bad day in the hospital and I was standing at the window feeling very sorry for myself and tears were rolling down my cheeks. Now I was just sobbing 'cause I felt so horrible and a nurse walked in to the room. And she was an old nurse, she had been around for a long time and she looked at me and she had this sort of look of panic in her eyes like she didn't know what to do with me now. So she moved to my bed... and she made my bed... straightened up the pillows and tucked in all the blankets and things and then...I had just turned away and I just kept on crying and looking out the window feeling kind of stupid 'cause she caught me basically ...but...finally I guess when it got too uncomfortable for her to do anything else... then she slowly came around to me at the window and she sort of put her arms around me but it felt that she was really hollow and wooden and she kind of patted me and she said "There, there that will be all right." And I didn't feel cared for or nurtured at all. What I felt was more that I was caring for her because she couldn't handle it. And so what I had to do for her was to say "I'm fine, you just go and I'm going to have a shower because I think that will make me feel better." And I could feel that sense of relief in her but the role had changed there from the person who should have been nurtured to the person who started nurturing somebody else because the nurse couldn't deal with the emotion. I thought...as it was even happening I was thinking, what an interesting scenario that's occurring, that a nurse who is obviously so experienced is so uncomfortable to say that she cared for someone you know. And then when she did it was very, very perfunctory and it was like she had read it in a book...*

In this vignette Ruth articulates beautifully the qualitative distinction of the caring touch. Earlier she had stated that "people know when they are cared for; babies know when they are cared for". When caring

provides the motivation behind the touch the patient is able to discriminate the qualitative difference. The nurse in this scenario is not able to enter into the caring moment which Ruth so obviously needs, someone to acknowledge and share her pain and desolation. Robin would call this "taking on the burden of another."

I could relate another vastly different occasion when a nurse "touched" a patient. My Dad had just been informed that he was dying. Why the doctor chose to tell him alone without the ready support of his family I will never know. However, it was done and Dad was alone to absorb the news. He told me the story of sitting on his hospital bed, tears flowing down his face. Debbie, a nurse, came to sit with him. Dad didn't say much. The nurse didn't say much either, but when she got up to leave, she leaned over and "gave me a peck on my cheek, right here." Bless you Debbie, for your timely and caring touch.

Barbara tells another story of touch. It is apparent that she wants me to be acquainted with the student prior to sharing her caring story with me. The involved stance of the nurse extends to the educator. Along with the instructor I am humbled by this wonderful student who has a profound grasp of caring.

> *We can start with a student... who um was a Native Indian and had lived through a traumatic life herself, had come through incredible odds to get admitted to the nursing program...I had her as an*

adult learner, she was about twenty seven when she was in the nursing program and had to do a lot of up-grading in order to meet the admission requirements to get into the nursing program. Academically she struggled; it wasn't a natural process for her and yet clinically...I guess she was an excellent example that a person's grades in academic terms don't necessarily make you a caring nurse. Because this student struggled so much and yet clinically she was just the most compassionate caring person I've ever seen in my life...and especially when you think about the trauma that she herself had.....

Barbara shared some of these childhood traumas with me but I do not have the privilege of relating them here.

But the one instance that stands out in my mind... She was on a floor with AIDS victims...people who were dying of AIDS and she was working a night and had this young AIDS person...this particular man was having a lot of problems...well you know yourself that AIDS is such a traumatic disease because there is such a strong social stigma...plus traumatic in terms of the physiological changes that take place in the body. He was feeling so rejected...rejected by his family and even rejected by the people in the health profession. Like, he was in a room by himself and often when they came in they would be gowned and gloved. So...he broke down in the middle of the night and it happened to be my student who was on with him...and he started sharing with her his experiences about feeling rejected and even how he felt that people were afraid to um...touch his tears because they were so afraid that they would contact the disease. And she spent about two hours in the room with him and she held him...in her arms...and he said it had been the first time that he'd been touched by anybody that didn't have gloves on for a long time. Because she was able to treat him like a human rather than an object that has a disease. He opened up to her and got out...a lot of these feelings of rejection over this period of over two hours...she didn't have him as a patient I think for the rest of the week and at the end of the

> *week he actually succumbed...pardon me...to his disease...he died at the end of the week but before he died she wrote a poem for him and read it to him and it was called 'Please Don't Touch My Tears'...and in this poem she expressed for him his feelings of rejection...and his feelings of being treated as though he was a non-person...and it was...it was an incredibly beautiful poem. He expressed to the instructor and also to the head nurse how the only person that he felt really related to him as a human being had been this student nurse who had held him that night and had touched his tears. She had wiped away his tears as he was crying. I guess it's a memory that I won't ever forget.*

Borrowing the phrase of another, to interpret the meaning of the behaviour of Barbara's student as caring seems "...no more than a profound grasp of the obvious" (Rawnsley, 1989, p.45). The student's conspicuous touch of her patient left a lingering impression with not only the patient, but also her instructor.

So much of what nurses do requires physical contact with the patient's body but not all opportunities for touch are as gentle as Barbara's example. Sometimes the nurse's touch will be uncomfortable or even painful. Gadow (1990) writes about the "chasm" created when nurses must not only enter the patient's bodily space but also inflict pain. In this next excerpt it is evident from Robin's response that, at the very least, a minimum of pain is expected when the nurse must enter the patient's bodily space. Robin was particularly dismayed when one student actually caused unnecessary discomfort to a

patient when removing a dressing.

> *I can remember one man who had a CVC (central venous catheter) and this student was just sort of tearing off the tape with hair on his chest and I would say well, support the skin and he just sort of continued doing it...he didn't have that genuine concern...you know which is caringness...you know, you don't fail somebody for not supporting the skin but you start getting sort of...some ...problems with your stomach. (Robin held her abdomen at this point in our conversation).*

While inflicting pain on others may sound discordant with the work of a caring professional, it is a common reality for practising nurses. Gadow (1990) discusses how nurses come to terms with inflicting pain, through disembodiment, treating others and consequently themselves as objects. She states that "...nurses learn early to regard patient's bodies as objects-to avoid embarrassing themselves and the patient while expediting awkward procedures, and to avoid feeling pain when inflicting pain upon patients" (p.37).

Ruth told me of one experience with a student when the student performed skilfully in giving a patient an injection but paid little attention to the patient before or during the injection. Ruth expected much more from this second year student and felt no hesitation in telling the student of her concern. The student responded that she felt it was her role to give the needle and the instructor would take care of the

psycho-social needs of the patient. "*I said to her...but you know there is a person on the end of what you are doing these things to....and she said that later on she would do that after she got better at giving needles!*"

Ruth and Robin do not accept this attitude of disembodiment. Indeed Robin's response to the student is embodied in her feeling of having "problems with your stomach". As with Ruth she wants to see some genuine concern for the patient. For Robin, the quality of the touch is a significant feature in determining how caring the nurse is. Gadow continues.

> Because caring involves learning to enter patients' worlds through embodiment, it requires infinitely personal devotion to the most mundane intimacies of physical care. Objectively, things like bodies have no dignity of their own. Science renders all things common. Caring inverts that reduction and addresses things like bodies as subjects-bearers of self-given meanings. Here we are on firm ground, because being living bodies ourselves, we have inside knowledge. (Gadow, 1990, p.38).

The nurse has a choice in entering a patient's bodily space objectively, (dis-embodied from the patient), or subjectively (and embodied). Caring affords the nurse the opportunity to enter the patient's space in an embodied way. The instructors I interviewed are alert to students who do not manifest caring in the way that they touch patients.

Caring as the Gift of Time

Another characteristic of caring pointed to by the stories and anecdotes of these instructors is the element of time. Clare recollects a story for me that she has often told to students.

> *I was going to tell you about a story of caring...I worked with a wonderful woman...I learned so much from her...But anyway, the one particular moment that I saw her caring ... (she cared all of the time)..But one evening ..it had been really, really busy ...and there was a gentlemen...He'd been a little restless that one night and he wasn't (her) patient but she had some conversations with him...he'd been in for a little while and I can't even remember what was the matter with him... but you know he was ok...he was sort of...not great in terms of disease but he wasn't...dying either...we thought...and so this one particular wildly busy night..you know the kind of night that you work overtime and you just want to get out of there and go home..and (she) was in charge and I was down at the other end and so I finished my work and I in fact I did go home. and um...well (she) said you go ahead, I'm just about finished I've just got a couple of desk chores or something to do.. and so that was fine and ... the next night she said you know something happened to me last night and what had happened was that something had called her to that man's room and...she went down there and the door was ajar and the room was in darkness. And she said she went and she called the man's name softly at the door and there was no response. She said..I was in that world of not one place and not the other but she said suddenly she knew she had to enter the room and she did...And the man turned on the light and...he said "sit down" and they talked for the next several hours and this man kind of went through a life review with her and she said she knew it was a critical moment for this person and despite her own exhaustion, and knowing she had to get up the next morning with her two year old she stayed... and when she left she settled the man and he took her hand and squeezed it and said thank you so much...and she left the room and ...went home ...and the man died a half an hour*

later...and so I have never ever forgotten that story ..or my friend ..and that to me is the meaning of caring...

Clare uses not an example but a metaphor of caring. She lays it before us as a gift, "and that to me is the meaning of caring". This story encapsulates caring for Clare, and she tells it proudly, as a witness to the substance of her friend. The generous gift of time and timeliness is exposed in this narrative. Reflecting back on the other stories presented here, it is apparent that time is often a significant factor. Be reminded of Barbara's student and the young man she held late into the night, or the hours Barbara's other student spent with the elderly couple who were estranged from their daughter. Robin wondered out loud why more health care professionals couldn't take the five minutes it took to write a letter to a little eleven year old girl. Time; taking time to explain, giving time to listen, choosing the right time to ask, making time in a busy shift. The gift of time is an important aspect of caring for these instructors.

While I have intentionally pointed to specific characteristics of caring revealed by the stories, they do not stand alone but are reliant on the particular context of the situation. Being involved, touch and time are set against the backdrop of the experience in

its entirety. "Only as we see the whole can we adequately appreciate the significance of the nurse's contributions..." (Benner, 1984, p.41). Caring nurses strive to see the whole of their patient's experience; they strive to understand the whole.

Discerning Caring

The experiences related here in story and anecdote facilitate and enhance the instructors' constructed meanings of caring. At this juncture we arrive at a significant turning point in the discussion. If these stories represent what caring means to these instructors then are they in fact evaluating caring against their own reality? Are nursing instructors granted opportunities to address or avail their own realities of caring as the touchstone for evaluating students' caring? This question provides a thoughtful backdrop to explore the conversations focusing more specifically on clinical evaluation.

One participant was very purposeful in describing how her notions about caring had changed with the significant events that had happened to her in the course of the previous year. That change affected her evaluations as she recounts in the following excerpt.

> *Caring in nursing means something different to me now than it did last year...partly because of my personal experience with having a critically ill friend who died, and my own experience in hospital*

> *because I've never been sick a day in my life and then ended up with three hospitalizations in a year.*

Ruth went on to explain how she used to value attributes such as the nurse's organization, efficiency, adeptness with skills, currency with knowledge but then....

> *All of those things went out the window for me, or many of them and now, having been the recipient of care in a different sense and the recipient of non-caring behaviour. What I witnessed in nurses in caring was more some of the ...the things that are really difficult to measure.*

Although Ruth had always valued caring in nursing it had not been the central feature of importance. With the personal experiences she faced in the past year her ideas had changed markedly. Now she doesn't "mind so much" if the patient's medications are fifteen minutes late or that the nurses knowledge base is current but is concerned that the patient has been "*...attended to...and that there is something special and uniquely valued...that the patient <u>feels</u> cared for and nurtured...*" She told me of an experience with a patient.

> *"...just after my friend died I spent some time with a patient who had a chronic illness and I was sitting at the bedside watching the nursing student do a dressing, The nursing student had to leave to get something....I said to the patient...so you must be able to sit here and watch nurses come and go all day..I said ..how can you tell which ones are concerned about you? ..or which ones really care?.....She looked at me as if I'd asked some profound question and she said*

> *you know, no-one's ever asked me that before. But I can tell you within 60 seconds of a nurse coming into the room whether he or she is caring...she started to tell me the things that she noticed, intonation and voice, the way they were concerned, whether they talked to you, how close they came to the side of the bed, the look in their eyes, body posture...she had some wonderful things to say...."*

The instructor then asked me "And how do you write in someone's (a student's) progress notes..I didn't like the look in your eyes?" We laughed together over the apparent absurdity of that statement but both of us were very aware of the reality of not liking the look in a student's eyes!

Whether it is the look in a student's eyes, or something else that the instructor grasps in a student's nursing practice which alerts them to a non-caring student, instructors do identify a shift in their way of being with these students. Robin talks about recognizing a lack of caring in one student.

> *And things just aren't right here you know...it's just not...you know that he's not responding (to his patients). So then I find that with him maybe I become more watchful. I wonder if my evaluation of students becomes more critical. I think that probably my evaluations become more cut and dried which means that I am becoming less caring.*

Barbara also describes a way of being with students which is more "cut and dried". She spoke about a student who did not have any insight into her own non-caring behaviour and Barbara found she resorted to using objective, concrete data to point out to the

student how inappropriate her behaviour was. "*The student sort of thought in black and white terms..this is what she could relate to that she had done wrong...but she had a lot of difficulty relating to the fact that in no way had she showed any...understanding of the individuality of this lady at all.*"

When students seem to have little comprehension, acknowledgement or sensitivity to patients as persons, these instructors make an effort to talk to the student about their concerns. Often it becomes even more apparent through discussion that the student really has very little insight about caring for and about others. The instructor becomes more watchful, and less forgiving than with students whom they recognize as genuinely caring for their patients. Robin shares her concerns about shifting to "power over", rather that "power with" students when she recognizes a lack of caring in a student.

> *I believe that the climate starts to become more adversarial. When I see that they've got that caring the climate changes so that the student is actually more liberated to be more in control of the decision making. But if they don't have those things (caring) I guess I have to start watching more. And in the watching I become their supervisor which now the power is with me. So the evaluation becomes more cut and dried and for me it's uncomfortable because it's moving away from really a caring way. But I guess the reason I do that is because I start now thinking of my accountability to this person who will be a nurse.*

While Robin's words may sound harsh, they are reserved

for a student who is very obviously unsuited to the profession of nursing. Robin described one morning she spent with the student when he not only made one medication error, but later that same morning repeated the medication error and had a total lack of regard for either of his actions.

The examples of students which Robin and Barbara related to me in the above scenarios are stark in highlighting that not everyone is suited to the practice of nursing. For these instructors one defining characteristic of being suited to the practice of nursing is their want or desire to care for and about patients.

One question that arises from that statement and was voiced by every instructor participant was "Can caring be taught?" The consensus was that if a student does not begin their nursing program with an inherent caring-ness (Robin's word is used here) then there is cause for concern by the instructor. While instructors can role-model caring (Nelms, Jones, Gray, 1993) and enhance the meaning of caring, instructors need at the very least to feel comfortable that the student begins with the premise of wanting to be caring of others. Being able to identify this inherent desire to be caring may be the underlying issue and the problematic of this study. Instructors observe for that promise in

their students and feel reassured when they witness caring. I did not sense that this process of attending to caring is necessarily a conscious decision on the part of the instructor. I found in my conversations relating to evaluation of caring that instructors more readily provided examples of evaluating non-caring than they could provide examples of actually evaluating caring. A lack of consciously attending to caring may be a reflection of the behavioral objectives not directly addressing caring or it may be that instructors assume students to be caring until they prove themselves otherwise. In any event they are troubled if they sense a lack of caring in their students. When students are quite obviously inattentive and indifferent to their patients, if they do not have that inherent sense of "caring-ness", then the instructors will relate objective data to substantiate the claim to their student that they are not well-suited to nursing. The students who do not lean to one caring extreme or the other are more difficult to evaluate, though instructors agree that they just <u>know</u> if a student has that "caring-ness".

> *The students that I have shared with you have been definitely superior on one side or inferior on the other. But look at all the students that are in the middle and somehow you <u>know</u> that they have it or they don't have it. But unfortunately those students are evaluated by getting down to what is concrete and maybe the caring gets lost...*

Robin feels that caring-ness is lacking when she recognizes that the student is unable to "*...make that connection and so ...she's not caring...and what is missing is more the humanness..the ability to respond.*" Robin claims that it is not difficult for her to recognize when a student has this quality but finds it almost impossible to describe.

Ruth speaks about the caring way of being of some new students. *The question for me is how would you teach that (caring) to someone because some of the students, who are brand new students, intuitively do it, it's part of who they are, it's part of the fact that they're caring individuals ...it's just what they do.*

Ruth's words bear repeating because they strike to the heart of the matter. "It's part of who they are, it's just what they do". Instructors claim that they are concerned when caring is <u>not</u> part of who students are or <u>not</u> part of what students do. They also claim to just <u>know</u> when such is the case with a particular student but are unable to fully describe how they know.

In conversation with Clare she attempted to simplify the issue by stating the following,

> *How do I know when I'm cruising by a room that a good nurse is in there?...what makes me say that is that I walk into that room...the patients are comfortable..and why are they comfortable because*

their basic needs are met...the beds. the linen has been changed ..the dead flowers are out of the flower containers...the IV is dripping on time...the NG is running...the patient in their pain can still smile at me when I go in and say Hi...now I don't know, that might sound very trite..but is nursing any more that? Sometimes I don't think it is."

Is nursing any more than that? Nursing and caring had become synonymous in this instance. I challenged her to look further by returning to her earlier recollection of her friend which certainly did not limit caring and nursing to tidy bedsides. She went on.

"...some of my most memorable moments with patients...I always go back to patients, my relationship with patients for the meaning...the first meaning...some of my most memorable moments...with caring...have been when I have been with patients ...straightening the draw sheet...and giving their back a rub...and tucking them in...because in settling someone for the night...it's like...settling somebody...helping somebody with life...oh I am really struggling with this...but it's not the rub...it's the place we are in when doing it."

Clare is struggling with the question "Is nursing any more than that?" Initially she sounds convinced that nursing (and caring) is really only a composite of the behaviours that we do "for" patients. She lists the concrete, specific, behavioral indicators of good nursing care. Pressed to go further however she talks about the importance of the relationship in "the caring moment". *"It's the place we are in when doing it."* For

Clare the connection occurring with and between the two people elevates the experience to one of caring. However, she recognizes that to demand that students will "connect" with every patient is an unreasonable expectation.

> *I think it is very difficult to...connect with everyone.. well we can't be a 'caring with' instructor for everyone of our students either...it's just not expedient....and um that's sort of that old phrase of life ..you can't be all things to all people..I don't reach all students as a teacher".*

Benner (1984) contradicts Clare somewhat by stating, "Almost no intervention will work if the nurse-patient relationship is not based on mutual respect and genuine caring" (p.209). I think Clare is speaking to the varying degrees of caring but she is not completely absolving students (nurses, instructors) of some level of caring for all patients. She expresses later in this discussion that she evaluates a student in context with all of the experiences she will have with that student and does not use isolated incidents of student-patient relationships on which to base her judgements. However, as Clare stated earlier, the one incident does tend to colour her judgement.

We spent some time discussing how intuition is becoming a valid way of knowing for Clare. She reflects on how she came to this realization several years ago.

> *On orientation day eight students come to us. I suddenly became aware that in a very few days of working with those eight students I knew who were going to be successful and who were going to be struggling. But I thought, My God I can't ever admit that to anybody because what proof do I have and so I sort of started watching. I guess I conducted this little experiment with myself. I realized that I was bang on.*

Clare is questioning whether she should be listening to her intuition. She mentions several times that she hoped she was not "just making value judgements". She remained very attentive to her intuition but guarded herself against trusting that way of knowing completely.

> *If a student is experiencing difficulty with being caring, that is, if I observe an incident they are not being caring, then my something in me says uh huh and the antennae go out. I say to myself there is an incident, I have to be attentive to that person not being caring. What I will be asking myself is: Is this one incident, or is it a pattern? Benner talks about pattern recognition of intuitive judgements and I really like that because that's just good old common sense really. Because one error does not a failure make but if it becomes a pattern then in fact it's not an intuitive judgement on my part at all. It becomes concrete data and then I can go to the student and say I first became aware that there may be a difficulty when I observed you ...*

I wrote in chapter three that instructors rarely place confidence in a knowing which is formed in a unique and personal way. While Clare is aware of the intuitive misgivings she might have of some students she looks further to substantiate with objective data what she intuits to be true. However, another turning point occurs when she decides to share her misgivings

with her students.

> *About a year ago I thought well, ok now that I have observed my own evaluative processes and have some confidence that this is ok to be knowing, almost immediately, that these things are happening for me...If I am so sure of this myself now, or after a few days, why shouldn't I be telling the students that?*

Actually Clare referred to the above as a "critical" turning point. This is a significant observation because it places an increased emphasis on a way of knowing not traditionally valued in nursing and education. It also places greater emphasis on a trusting relationship between student and teacher. The teacher is willing to share her tentative thoughts with the student knowing that within the existing evaluation method those intuitive judgements would not be endorsed. However by sharing her initial perception Clare offers the student access to broader knowledge which will, she hopes, engage the student in the process of creating their own meaning of caring. Robin agrees by relating her own evaluation practices. When I asked her if she can evaluate caring, Robin had this to say.

> *Well I guess if you want to do it from an objective point of view...um you probably can't.. but I don't see anything wrong with putting subjective data in the evaluation. So I have no problem saying...you seem to be very caring.. you know...committed to your patients and you seem to be connected or whatever. Or there are so many times that I don't have any problem saying..you give very good physical care but I don't feel that there is any connection between you and your*

patients. I don't have trouble with writing stuff like that. I guess because what's next is the dialogue that goes along with that. I don't think that you just sort of say these things. I think that whatever our comments are about caring, if we're doing it caringly. I figure that almost promotes the dialogue between us. The whole idea of that conversation I think is to hopefully give all of us insights into what we're doing and why we're doing it...how it's coming about. I think it will then also help us with insights in our practice...and I think that is the job of the teacher to help the student find the meanings...

Who Am I - Teacher or Evaluator?

Clare and Robin's statements are very revealing because they point to and highlight the intertwining roles of clinical instructors. They are at once both evaluator and teacher. This view of merging the teacher and evaluator role is contrary to behaviourist theory as expressed by Bevis (Bevis & Watson, 1989). "The common practice in nursing education, especially clinical teaching, of attempting to keep a strict separation of teaching and evaluation springs from a research tradition as well as from the character of the behaviourist paradigm..." (p.271). Clare and Robin expressed concern that their evaluations should be perceived by the students as learning opportunities. Additionally the relationship between the student and teacher will have a significant influence on how that evaluation would be perceived by the student.

All of my participants were concerned that their

evaluation of students should not close down the conversation between instructor and student but as a tool for enhancing the dialogue and relationship between them. The ultimate purpose of these evaluations should serve to enhance the student's nursing practice. Robin states that she does not have a problem using "subjective" data in her evaluation. In fact that is not the real issue. The issue is <u>how</u> those thoughts are presented to the student. *"I mean if we are doing it caringly I figure that almost promotes the dialogue between us"*.

Robin is focusing on the quality of teacher-student interactions and relationships. Bevis (Bevis & Watson, 1989) believes that the teacher's role is to nurture the student learner.

> The teacher's role is to nurture the learner: to nurture the ethical ideal, to nurture the caring role, to nurture the creative drive, to nurture curiosity and the search for satisfying ideas, to nurture assertiveness and the spirit of inquiry together with the desire to seek dialogue about care and to be available for that dialogue (p.174).

When students believe that their teachers have their best interests at heart, when they feel they have "power with" (Robin, in conversation) their teachers, when they are genuinely listened to and experience dignity and worth in the relationship, students will be enabled to openly dialogue about their nursing practice. The teacher sets the climate for such a

relationship to develop.

A way to begin is suggested by Belenky et al (1986) when they discuss connected teaching. They make the claim that students will be more empowered to develop their own critical thinking skills and create their own knowledge from within if their teachers acknowledged their own imperfect and incomplete understanding. "Our teachers appear to us first in the guise of gods and are later revealed to be human. We think the revelation might occur sooner if those of us who teach could find the courage-and the institutional support-to think aloud with our students" (p.216). Students need to feel support in "giving birth" (p.217) to their own ideas and they will be less intimidated to do so if they realize that teachers also at times are a little muddled in their thinking. "They need models of thinking as a human, imperfect and attainable activity" (p.217).

Thinking aloud about caring and its relationship to nursing practice requires dialogue with students about their personal constructions of that concept. Conversations like the ones I experienced with participants in this study could be invaluable to students developing their own meanings of caring. Students need opportunities to dialogue with experienced nurses such as instructors to understand

the limitless possibilities for caring in nursing. Some of those possibilities have been discussed here but other nurses have their own stories to tell. Students should be encouraged to create their own meanings from the shared experiences of experts and from their own stories.

Though the three themes of being involved, qualitative touch and the gift of time were exposed in the presented stories there is no doubt that other characteristics could be pointed to in the same narratives. Indeed, other stories of caring would reveal other themes. That is the nature of this highly personal concept. I was affirmed in my assumption that caring cannot be adequately understood through distancing yourself from it because caring is a concept which inherently demands nurses to personally grapple with its meaning <u>for them</u>. "Caring requires both listening and a form of knowing that goes beyond curiosity and dissection, beyond laying bare the facts. Caring requires a truth theory that is true to the knower and the known" (Benner, 1990, p.5).

Understanding caring, evolving a personal "truth theory" about caring seems the necessary first step for nurse educators who want to embrace caring as the guiding theme for nursing curriculum. The clinical instructors I interviewed all have taken this necessary

first step as displayed by their ability to articulate caring in nursing through their own stories. It strikes me that the ability to discuss caring from a personal perspective takes caring into the realm of the familiar rather than into the more abstract world of theory. The constructed meanings arise out of experience and reflection on that experience.

The participant instructors interviewed for this thesis offer insight into how we might acknowledge other ways of knowing in relationship to caring. One means is to help students develop their own meanings of caring. By doing so we will begin to answer the question "Can caring be taught?" This process of assisting in creating meaning should begin early in the student's education project and be encouraged throughout it. "To produce that kind of personal discovery of meaning...it will be necessary to place far less insistence upon the weight of authority, proof, and evidence while we encourage students to do their own looking, discovering, and thinking about professional problems" (Combs, 1965, p.37). Instructors might create learning opportunities to specifically observe nurses' caring, to acknowledge and enhance caring in student practice, and to reflect through dialogue on individual perspectives of caring.

I have pointed to what seemed significant in the

stories and anecdotes four participants related to me when I asked the question "How do clinical nursing instructors evaluate caring?" By no means complete, these stories and interpretation offer insight and understanding into that question through dialogue. Meanings of caring are found in real, concrete situations where the elements of being involved, qualitative touch and gift of time are distinctive features of the caring nurse.

These personal meanings of caring inform the instructors' evaluations. While these stories are likely outstanding memories of caring, instructors seek some resemblance to their own meanings of caring in their students' everyday practice. They revel when they witness caring and reward the student with more equality in their relationship and confidence in their nursing practice. When instructors cannot see caring-ness in a student they are troubled. A lack of caring is often exhibited in the behaviour of students. Instructors sense a lack of caring through what they describe as intuition, a feeling, or "*just knowing*". There is tension created for the instructor when they cannot legitimately respond to these other ways of knowing in their evaluation practices.

Supporting the Teacher in Evaluation

Openly acknowledging the limitations of current evaluation practices will assist instructors to pursue other ways of knowing in accessing student learning. What we are able to evaluate with a reductionist evaluation method are isolated skills. For example, we can evaluate empathic responses as a communication skill or we can observe the student's touch of a patient. These observations are important but they are incomplete because they negate or de-value other ways of understanding our students' caring. What is required is endorsement to pursue other ways of understanding or knowing such as those ways discussed by these teachers and examined by Carper (1978), and Belenky et al (1986) in a previous chapter. Clare suggested that her intuition makes her more attentive to some students and that her intuitive misgivings are borne out in time. Robin said that she has no problem sharing her subjective thoughts with students with the proviso that there is an opportunity to dialogue caringly following those disclosures. Barbara labelled her way of knowing as a "feeling" which was hard to measure. It is time in our evolution in nursing education to sanction these and other ways of knowing in clinical evaluation. Moreover, it is time to sanction other ways of knowing in the practice of nursing such as Carper (1978) and

Belenky et al (1986) have suggested.

Some nurse educators would oppose suggestion about acknowledging multiple ways of knowing in clinical evaluation. One recently published article is entitled Factors that interfere with clinical judgements of students' performance (Orchard, 1992). The author warned of the fallibility of clinical instructors because they might unconsciously be influenced by such factors as performance expectations, appraisal subjectivity and degrees of inter- and intra-rater reliability of student clinical appraisals. The author further discussed strategies that would decrease the influence of these factors. The tone of this recent article reminded me of Lenburg's (1979) suggestions which I quoted earlier and will repeat here. "To be fair the test must be uniform, and equivalent for all students and judged by the same criteria by all of the faculty involved" (p.2). While I agree that some aspects of nursing can be judged with "...predetermined variables, objectives, and outcomes..." (Orchard, 1992, p.312), I would posit that those aspects are relatively few given the complex and relational quality of nursing. Of particular note, and in the context of this study, caring cannot be one of those aspects to be evaluated in the manner suggested by Orchard and Lenburg for the reasons stated above. What is required

required now to move forward in nursing education with emphasis on caring in clinical evaluation? We require an orientation which acknowledges the multiple realities or ways of knowing of the clinical instructor and places more credibility on the instructor's judgement. In fact, instructors are employed by nursing programs because of their advanced education, clinical skills and nursing practice experience. We must begin to trust that this combination of expertise serves us well in developing judgements about students. We also require an orientation that demands more of the instructor as an individual who is caring. The caring of an instructor may also be characterized by a willingness to devote involvement, time and perhaps a quality in their touch. There seems agreement with not only my participants but also in the literature (Bevis, & Watson, 1989; Komorita, Doehring, Hirchert, 1991; Orchard, 1992) that our subjectivity plays a role in those judgements. In the past, painstaking measures have been adopted to prevent that 'subjectivity' from entering into the evaluation of students. I think it is time that we acknowledge those other ways of knowing more openly and honestly with ourselves and with our students.

I am not suggesting that we should discard all clinical evaluation tools of the past but rather that

we should regard them in context with other worthy means for assessing learning. One valuable "tool" (if you will) are teachers themselves. We must remember that clinical instructors are professionals who want their students to be successful. One assumption underlying this attempt to demand that all clinical evaluations are uniform and equivalent for all students is that without those strict guidelines, instructors would run amuck and play havoc with student evaluations. Appeal boards would be kept busy night and day. I think not. The stories shared with me by these participants and my own experiences with students failing clinically is that instructors will go to many lengths to ensure that students have numerous opportunities to improve and to be successful in the clinical forum. The evaluator does not cease to be the teacher at the time of evaluating. Instructors take student failures as personal losses and will work diligently with students to help them be successful if at all possible. The assumption that instructors cannot be trusted with their judgements undermines the professional nature of the work that they do. In fact, one stated critical concept of this new curriculum (Hills, unpublished) is that there are multiple ways of knowing and to be true to that concept we must begin with ourselves and our practices. Clinical instructors

must now begin to acknowledge and understand how multiple ways of knowing inform their evaluations.

CHAPTER SIX

> Imagine that instead of wanting to order the world, our purpose in knowing is to recover the world and our place within it. Our working assumptions will be the opposite of those science requires (Gadow, 1990, p.7).

UNDERSTANDING IN CARING: CARING IN UNDERSTANDING

The intent for this thesis was to construct an understanding of how clinical nursing instructors evaluate caring. The question served as an invitation to think about how multiple ways of knowing inform the instructor's understanding. A hermeneutic inquiry was employed to construct meanings of caring and further engage those meanings to understand how they have an impact on the clinical instructors' evaluation. The interpretive inquiry began by considering the difficulty participants experienced when asked to describe caring but found a worthy vehicle in the use of story to depict their meanings of caring. From the stories the themes of being involved, the qualitative touch and time were suggested as characteristics of caring. A note of caution was assumed to remind us that these themes were always embedded in the context and situatedness of the story.

Evaluation of caring was then explored and several salient features from those conversations were captured. Instructors revel in percieving caring in

their nursing students' and cannot always articulate specifically what that understanding is based on. Instructors highlighted in story that the student's attention to, and involvement in the unique experience of the patient was important for evaluating caring. They also alerted me to the quality of the students' touch and the element of time in evaluating caring. But for the most part the experience of evaluating caring seems to be a recognition or understanding in an ontological sense. By this I mean they sense in the student a way of being that the student brings to the relationship with the patient. Robin stated that caringness is pervasive in the way a student approaches others in the world, not only with patients but even with peers in the classroom. It is a recognizable yet intangible substance or quality which does not lend itself to definition or abstraction.

If a student is quite obviously indifferent or non-caring to patients, instructors may use objective data to highlight for students how un-suited they seem to nursing. Most students however are not un-caring to that extreme and the instructor's texts reveal that their roles of evaluator and teacher merge. Instructors are highly motivated to assist their students to be successful in nursing. Nursing instructors strive to teach and evaluate <u>caringly</u> as it

is not only considered the essence of nursing practice but also of nursing education.

It is not reasonable to briefly summarize a work which relies on text and interpretation in an attempt to make plain or evident the writings contained within. This work however does contains a number of themes which might be looked at within a broader frame of reference.

I have come to the thoughtful conclusion that we may be unable to evaluate caring within the traditional paradigm that still objectifies nursing education. The experience of caring is larger than a sum of its parts and must be viewed in wholeness. It is impossible to extract the essence of caring without reference to the whole. Caring becomes further distorted when viewed within the reductionist evaluation framework of behavioral objectives and as nurse educators, we must find other means, forms of inquiry and ways of knowing for accessing this aspect of student nurses' practice. I would also assert that these reductionist methodologies cannot account for the personal constructions of the meaning of caring. What nurse educators are better situated to do as regards caring in nursing is to understand how students are oriented to caring in their practice and help them evolve their meanings of caring.

The themes of understanding and caring are intertwined and pervasive throughout the thesis. It is the search for understanding which inspired and drove the methodology. As much as the concept of understanding has significance to this study by way of seeking understanding over explanation, so too is there relevance for the notion of understanding in relationship to caring. Nurses are not always seeking so much to explain the experiences of their patients but also seek to understand another person's reality. The basis of the ability to respond to another person, a patient, is anchored in a caring relationship which enables and facilitates understanding. I would suggest that a nurse's caring and understanding are not mutually exclusive, rather they harmonize, each reinforcing the other.

I believe that the themes of understanding and caring also have relevance to the conversations I have had with the instructors. No doubt similar to other professionals who share like experiences, there is often unspoken agreement and understanding perhaps more revealing than what is actually said. Nurses speak together with a common language full of nuances and shared meanings. My colleagues and I approached the question within the shared context and experience of nursing practice and education. We share a mission to

prepare nurses for practice who are caring in both their knowledge and their being. I think it was instrumental to the research that participants could recognize that I share that commitment and mission which was reflected in my initial proposal and later in my conversations with them. Without that understanding, the instructors would have been less willing to reveal their experiences and thoughts to me and further would have not allowed me to probe their disclosures. There is a consistency between this way of being with participants in research and nurse-patient relationships in health care settings. For in a desire to understand the patient's reality, the caring nurse enters a conversational relationship with the patient. The nurse listens attentively when stories are being told and genuinely attempts to understand the meaning of the patient experience. There is a much different atmosphere created in a conversation as opposed to an interview. This atmosphere facilitates disclosure in dialogue to further the creation of meaning together. Patients will presumably experience the relationship differently if they feel that the listener genuinely wants to understand them and help them to make sense of their experience. This consistency between the methodology of this study and the study itself lends authenticity

to the written text.

Another notion that is highlighted by this inquiry is the diversification of roles by the clinical instructor within a reductionist framework. Instructors must be both teacher and evaluator and the assumptions that underline those roles are at odds with one another. The teacher is expected to be caring and understanding in order to facilitate students' nursing practice. Caring and understanding are not normally extended to the role of evaluator. In evaluation teachers are expected to be more objective and not influenced by the knowing which evolves from their relationships with students. They are expected to gather together observable behaviours and with that collection make an appraisal or judgement about the student's practice. All of this is to be accomplished under the guise of objectivity so that no charge of bias can be made. Nurse educators need to reconceptualize the roles of teacher and evaluator into one role of teacher. In fact it may be through a caring and understanding orientation, made possible through multiple ways of knowing, that instructors are better able to discern the "caring" in their student's practice.

Implications for Nursing Research

This hermeneutic study makes no claim on generalizability but is limited by the element of time, a recognition that I conversed with four participants and my interpretation of those conversations in reflection with my own understanding. Van Manen (1990) has said that a human science requires that we "... believe in the possibility of understanding the world by maintaining a thoughtful and conversational relation with the world" (p.16). This study will have been successful if it invites the reader to enter into a dialogical relation with the question posed and the text revealed. It is through this dialogical relation that readers might be moved to action (Van Manen, 1990).

> And so to become more thoughtfully or attentively aware of aspects of human life which hitherto were merely glossed over or taken-for-granted will more likely bring us to the edge of speaking up, speaking out, or decisively acting in social situations that ask for such action (p.154) .

Action in the above sense might take the form of clinical nursing instructors questioning the manner in which they evaluate the caring of their students, or an attentiveness to exploring their own meanings of caring.

Implications for further research are numerous. As a continuation of this study it would be helpful to have participants respond to this text in a focus

group to push the dialogue yet further. This opportunity could provide an understanding of the shared and different meanings of caring of clinical nursing instructors and how those meanings of caring impact on their evaluation.

It would also be interesting to know how clinical nursing instructors would view the question if they were not involved in a paradigm shift in nursing education. I suspect that being actively involved in questioning the tenets of educational practice will predispose a participant to being more open to possibilities and other ways of thinking. A study of instructors from a behaviorally oriented nursing program would possibly disclose a different understanding.

Seeking Closure

I began this study with a curiosity about nurses' multiple ways of knowing. Exploring a concept without a context to frame the inquiry seemed far too abstract. As caring in nursing was also fast becoming an important notion for me I decided to orient my inquiry to caring with emphasis on nursing education. The question of how clinical instructors evaluate caring evolved from those initial ideas. I was well situated to ask the question, employed as I was at the time as a

clinical instructor. I am now involved in a broader context of curriculum activity and with that enlightened perspective the question I raised also broadens to embrace many aspects of curriculum development, implementation and evaluation in nursing education. The underlying intent of all curricular activity is to provide students with opportunities which will prepare them to practice as professional nurses. The exemplar stories of caring in nursing practice offered by the participants are hopeful visions for what nursing practice might more noticeably look like in the future. These stories speak strongly for why caring must continue to claim a stronger presence in nursing practice and education. Preparing nurses with a commitment to caring requires an approach which encompasses the whole, not a reductionist gaze which views the parts in isolation. As nursing instructors we need to enter into more conversations rather than interviews and seek understanding over explanation with our students, with our patients and, perhaps with ourselves.

> We cannot conceive of knowing in any partial way as sufficient. We cannot rely on any one way of knowing that disregards another dimension of experience. We know we experience reality in a whole way (Chinn, 1987, p...).

I close with the hope that this study provokes readers to explore their own meanings of caring,

understanding and evaluation in nursing practice and education.

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Appendix A

LETTER OF INTRODUCTION TO THE RESEARCH

Dear (participant)

Thank you for agreeing to participate in my research looking at multiple ways of knowing in clinical nursing evaluation. I would like to explore how your "knowing" is shaped through your subjective senses, "gut" instincts, hunches, intuitions, personal experiences, objective data etc. Please do not be limited by my choice of wording as the understandings arising out of our conversation will be shaped through language. I do not want to limit or hamper your comprehension of your own practice through my choice of words. I am keenly interested in how those understandings transform, inform and are brought to bear in your formative and summative evaluations of students.

I would be requesting that you read my proposal and then allow us an opportunity to dialogue about your experiences in evaluating your students' caring. I am interested in what you do with those thoughts, feelings, notions which may or may not have an impact on your "objective" accounts of students clinical practice. I suspect this conversation will take approximately three hours, at your convenience. The conversations will be taped.

Prior to our discussion it would be helpful to reflect on past experiences which you think have some relevance to this exploration. You may wish to "journal" about these experiences. I am hopeful that the following questions will serve as a helpful focus for our discussion.

1. What does "caring" in nursing mean to you?

2. Can you describe an occasion which exemplified a student caring? What led you to this conclusion?

3. How did this occasion impact on your evaluation of your student?

4. Can you describe an occasion in which you felt the student was not caring? What led you to this conclusion?

5. How did this occasion impact on your evaluation of your student?

Following our discussion I will be listening thoughtfully to the tapes and exploring for exemplars, patterns and suggestions from the collective of participants. You may request to read the final draft of the thesis before final submission to my committee if you wish.

Please feel confident that our conversations will remain confidential. Tapes and transcripts will be destroyed after analysis. I would request that you choose a pseudonym for the written work. The educational institution where you teach will not be identified in the written work.

Please be aware that you can withdraw from this research at any time. It is not necessary to provide reasons for withdraw. If you do choose to withdraw any data collected will be destroyed and not used in any part of the research.

Thank you. I appreciate your time and energy which this will entail on your part and I very much look forward to speaking together.

Cathy Clark

Appendix B

CONSENT TO PARTICIPATE IN CATHERINE CLARK'S RESEARCH

I have read the description of Catherine Clark's study of multiple ways of knowing in clinical nursing evaluation and agree to the following conditions of my participation:

1. I understand that anonymity and confidentiality will be strictly observed.

2. My name, identifying characteristics or status will not be used in the written thesis.

3. I may choose a pseudonym for the written work.

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