Nursing students' experiences of being and presence: a hermeneutic approach

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Nursing Students’ Experiences of Being and Presence:
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The profession of nursing is both an art and a science. Although nursing practice intertwines the art and science of nursing, nursing education focuses on the scientific behavioral outcomes of learning content knowledge and nursing skills. The behaviorist scientific curricula of most nursing schools are not congruent with nursing practice. Therefore, the outcomes of nursing education do not pedagogically match the objectives of nursing practice. Nursing educators do not know how nursing students learn to intertwine art and science, the being of nursing. The purpose of this study was to understand how student nurses make meaning of experiences of being in nurse/patient interactions. This study was conceptualized using Heidegger’s philosophy of being and Vygotsky’s social constructivist theory of learning. Heidegger’s philosophy describes being as a
process or activity of existing. Vygotsky’s theory describes the learner as a constructor of knowledge who actively searches for meaning in transactional, socially-constructed situations.

The participants were 28 sophomore nursing students, enrolled in a basic fundamentals course, and in the first year of clinical experiences with patients in acute care settings. The participants self-selected experiences to ejournal by answering six open-ended questions concerning their thoughts and feelings of being in nurse/patient interactions. The data were analyzed using an interpretive process true to hermeneutic phenomenology. Five themes were identified: fear of interacting with patients; developing confidence; becoming self aware; connecting with knowledge; and connecting with patients. A possible sixth theme was experiencing sacred space.

The relevance of the research is the understanding of the process of learning as uncovered in the students’ experiences. Four conclusions were drawn from the study: student nurses intertwine the art and science of nursing in nurse/patient interactions; nursing education must be restructured to include a balance of the art and science of nursing; reflection and/or journal writing is a valuable way to enhance learning; and student nurses are developing identity simultaneously as a nurse and as a person. Nurse educators could therefore enhance optimum cognitive and psychological learning in the clinical and classroom environments.
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Dedication

Salle Jayne McCoskey Easter,
I dedicate this work to you – the first nurse I ever knew.

Mom, you lived the art and science of nursing every day of your life. Through your lived example you taught me how to experience being as a woman, a nurse, a friend, a wife and a Christian. I know you taught me how to experience and share sacred space.

May we share sacred space together in Heaven.

I love you with all my heart.
Sue
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Chapter One

Introduction

The most beautiful experience we can have is the mysterious. It is the fundamental emotion that stands at the cradle of true art and true science.

Albert Einstein (1932)

I am a nurse. This statement is powerful because I believe the role of a nurse is not just a job but a way of being. Throughout 27 years of nursing, I have experienced nursing through multiple roles and in a variety of settings. I have been a bedside staff nurse, nurse manager, and clinical nurse specialist in coronary care units; I have been a nurse specialist in cardiac electrophysiology laboratories and dialysis units; I have directed the care of patients as a cardiac transplant coordinator; I have cared for the elderly in long term care; and I have taught college students through baccalaureate nursing education. No matter where I have lived or continue to live the experiences of nursing, I have discovered the essence of nursing can be found in the interactions between the nurse and the patient. I believe these interactions are so special and so fundamental to nursing that they are sacred. I believe the being of the nurse and patient in these interactions is a sacred space.

I know time and experiences have shaped my definitions of, knowledge about, and ability to be in the sacred space of a nurse/patient interaction. Through my own experiences of living the sacred spaces of nursing, I have observed that
nursing is both an art and a science. As a nurse, sharing sacred space is being
present with a patient (art), and having knowledge and skills to care for the patient
(science). Many nurse experts have described both the art and the science of
nursing through research and theory in nursing practice. The intertwining of the
art and science of nursing practice can be seen in the story of a patient who has
chronic bronchitis. The nurse listens to the patient’s lungs, takes vital signs, gives
the patient medications (all science). The nurse then gets a special snack for the
patient, and while the patient enjoys the snack, the nurse rubs a special lotion to
soothe the skin onto the patient’s back (O’Brien, 2003). These artful acts are
examples of the intertwining of the art and science of nursing.

The wealth of knowledge about the art and science of nursing continues to
define and strengthen the profession of nursing. As a nurse educator, I have
observed that student nurses learn the science of nursing through classroom
content and through using skills in practice. I have also observed that student
nurses learn the art of nursing through repeated interactions with patients, either
by watching an experienced nurse interact with a patient, or by being in an
interaction with a patient as a nursing student. Identifying how students learn the
science of nursing is relatively straightforward – giving an examination to
measure content learned or observing a student using a nursing skill. However,
identifying how students learn the art of nursing is more complex, as each
nurse/patient interaction is unique, and experienced individually. Because I came
to understand that I do not know how student nurses learn the art of nursing, I
began to dwell with the topic of nursing education, and in particular the authentic
interactions of student nurses with patients. I realized I do not know what student nurses experience in nurse patient interactions. After a thorough review of the nursing education literature, I realized there is no documented research of student nurses’ authentic interactions with patients. The research presented here explores how student nurses describe the experiences of being and presence in nursing through interactions with patients.

**Background**

The profession of nursing has developed and changed dramatically over the past two centuries. Nursing began as an art, or genuine caring, by women who nursed people who were sick. In those early days of the profession, women provided mostly domestic care to the sick – bathing, feeding, comforting, turning and touching the person, as well as cleaning the environment of the sick room (Peplau, 1988). Nursing evolved to include an expertise of skills and knowledge, well supported with scientific nursing theories. In the 21st century, nursing is a holistic, caring discipline supported by all the skills and knowledge from educated nurse professionals. The art and science of nursing have certainly evolved, yet both art and science have remained woven through the history of the profession (Doheny, Cook, & Stopper, 1997).

The art and science of nursing was described by Paterson and Zderad (1976) as an application of the science of nursing into each individual, authentic, nurse/patient interaction. Through repeated interactions with patients, an individual nurse develops to define his/her personal knowledge and expertise as a nurse. Through years of research within the profession of nursing, the expertise
of nurses has been defined and documented. The elements of nursing that become key to understanding the practice of nursing are the science of nursing, the art of nursing, the nurse/patient interaction, caring, presence, sacred space, and \textit{being}. Each of these elements is discussed briefly here, leading to the statement of the problem and significance of the research.

The science of nursing is the content, skills, and knowledge of nursing practice (Donahue, 1985; O’Brien, 2001). How student nurses learn the science of nursing has been well researched and defined. Traditionally, the science of nursing is taught through content in the classroom and through skills performed by students in a laboratory and clinical setting. The evaluation of student nurse learning occurs through examinations and through successful demonstration of step-by-step performances of the skills needed to be a nurse.

The art of nursing is more complex to define and quantify. The art of nursing is experienced individually in each interaction of a nurse with a patient. The art of nursing is created and develops from the humanness of the nurse with the patient. Traditionally, behavioral communication skills laboratories, or practice scenarios with a nursing instructor, are how nursing students learn the art of nursing. Since the art of nursing is experienced in each interaction with a patient, the essential core of nursing exists in a nurse/patient interaction. The element of caring is the concept that intertwines the art and science of nursing in these interactions.
Caring is an essential human interaction. In nursing, caring expresses how the nurse delivers the skills and knowledge of the professional interactions of the nurse with the patient. Caring was defined by Touhy (1994) as:

a mutual human process in which the nurse artistically responds with authentic presence to a call from the client. The experience of nursing takes place in nursing situations: lived experiences in which the caring between nurse and client fosters wellbeing. (p. 8)

Caring leads to the next element, so key to the profession of nursing: presence. Presence is defined as the “nurse’s physical being there and the psychological being with a patient for the purpose of meeting the patient’s health care needs” (Gardner, 1985, p. 317). A nurse who is present with a patient is “being there” with the patient, not by objectifying but by experiencing responsibility or regard for the patient’s vulnerability as a person. The nurse is physically present to deliver the care needs of the patient. Four levels of presence experienced by the nurse with the patient have been identified by Osterman and Schwartz-Barcott (1996). Each level of presence is a more involved and intimate sharing between a nurse and a patient. The most intimate sharing is a transcendent presence, which can become a sacred interaction, or sacred space between the nurse and patient. Sacred space is not experienced frequently between a nurse and patient; sacred space is a unique wholeness and the space between you and I, the “and” where the nurse and patient connect (Wright & Sayre-Adams, 2001).

The concept of being is an element that describes the process or activity of existing. First described by Heidegger (1927/1962), being can only be described as a “relatedness backward” (Heidegger, 1962/1999, p. 277). The way to understand being is through this “relatedness backward” where an object is not
being studied but looking back at a process is being studied. To understand being, then, is to look backward at an experience or situation after it has occurred and to focus on the process that occurred. For example, to fully understand the experience of being in a nurse/patient interaction, I must reflect back on the process of what occurred after I am no longer in the interaction. If I am in an operating room watching surgery for the first time, I can obviously see the surgeon’s actions – the object of this particular experience. If I want to understand how it felt “to be” in the operating room – what being in the operating room was like – I reflect back on the experience. I can then remember the smells, see the teamwork of all the people in the room, remember communication that occurred in far more ways than words, hear the beeps of the monitors, and remember the cold temperature of the room. This example is how I best experienced being in the operating room. Caring, presence, sacred space, and being all intertwine to begin to define the art of nursing.

Statement of the Problem

As caring, presence, sacred space, and being are experienced in a nurse/patient interaction, these elements begin to define the art of nursing. The addition of the knowledge and skills of a nurse into the nurse/patient interaction is where the art and science of nursing start to intertwine to become nursing practice. Nursing practice is the lived experiences of the nurse in providing care to patients through the art and science of nursing (Benner, 1984; Hampton, 1994). The literature clearly states the importance of the intertwining of the art and science of nursing in defining nursing practice. Many articles and textbooks
include a statement that “nursing is both an art and a science.” (Bottorff, 1991; Bournaki & Germain, 1993; Chinn & Watson, 1994; Donahue, 1985; Hampton, 1994; Johnson, 1991; Watson, 1999).

If the definition of nursing practice is the lived experiences of the nurse in providing care to patients through the art and science of nursing, then how do student nurses learn how to be practicing nurses? How do student nurses learn to be? Various methodologies of teaching the science of nursing are described in the nursing literature. The literature identifies how nurse educators can assist student nurses to learn hands-on skills, and reports various research on how to enhance problem solving and critical thinking skills (Becker & Neuwirth, 2002; Clayton, Broome, & Ellis, 1989; Haffer & Raingruber, 1998; Hughes, Wade, & Peters, 1991; Myrick, 2002; Nehls, Rather, & Guyette, 1997; Oermann, & Navin, 1991; Olson, Gresley, & Heater, 1984; Scheetz, 1989; Youngblood & Beitz, 2001). How student nurses learn the science of nursing is, therefore, well described. How student nurses learn the art of nursing, or the art and science of nursing in authentic nurse/patient interactions, is not described nor identified in the literature.

Perhaps the reason the nursing education literature does not identify how students learn the art of nursing is because nursing has traditionally taught from the Tyler method of behavioral objectives and linear outcomes – a scientific methodology of education (Tyler, 1949). Nursing education is based upon the science of nursing; in comparison, nursing practice is an intertwining of the art and science of nursing. Therefore, the behaviorist scientific curricula of most
nursing schools are not congruent with nursing practice. Newman (1997) saw nursing practice as active involvement, and defined nursing as a “dynamic, relational process,” and noted that “to understand it we must engage in the experience of it” (p. 37). As nurse educators, we are embedded in what we want to teach – assist students in learning to experience the art and science of nursing. We must not take just a part of nursing, the science, and expect student nurses to begin to understand how to be in nursing practice.

Chinn and Kramer (1995), Newman (2002), and White (1995) discuss nursing practice as a weaving, or patterning, of the four different ways of knowing as defined by Carper (1978). Chinn and Kramer suggest “nurses routinely encounter situations that require decisions and actions for which there are no scientific answers” (p. 4). Knowing that nursing practice is a holistic patterning of the art and science of nursing, then why does nursing education continue to teach nursing based on a traditional scientific behaviorist curricula? In other words, nursing education focuses on Carper’s empirics way of knowing, or science of nursing, and neglects the other three ways of knowing, the art of nursing.

Because nursing practice is a holistic intertwining of the art and science of nursing, and nursing education is broken into scientific and theoretical outcomes, the outcomes of the education do not pedagogically match the objectives of nursing practice. Nursing pedagogy must be more closely aligned with the intertwining of the art and science of nursing in nursing practice. Nursing education focuses so much on teaching skills and knowledge to student nurses
that the artful caring of the nurse in the delivery of care is lost. Bevis and Watson (1989) wrote a textbook dedicated to the need for a new pedagogy for nursing. The authors proposed that the traditional behaviorist curricula in schools of nursing must change from a science-based, linear focus to an active, student involvement in learning through interactions and transactions between student and faculty. Nursing educators need to teach nursing intertwining the art and science of nursing – for what makes nursing unique is the caring presence of the nurse in the midst of the frightening health care environment (O’Brien, 1999). The student nurse must therefore be educated to be a sound practitioner in the being of nursing practice.

Nursing education research describes behavioral skills laboratories (Doane, 2002) and communication lectures (Kotecki, 2002) as methodology used to teach students how to interact with patients, but does not describe authentic nurse/patient interactions as the methodology to teach students how to be in the art of nursing. Traditional behaviorist pedagogy focuses on knowledge that is fixed and will be replicated, repeated, and regurgitated as students learn the knowledge. Nursing education continues to subscribe to behaviorist pedagogy. Traditionally, clinical experiences, behavioral skills laboratories, and communication lectures have been the accepted methodologies for student nurses to learn the art of nursing. All of these teaching/learning methodologies have set objectives and are a linear, science behaviorist approach to education. However, the art of nursing must be learned in authentic nurse/patient interactions, where active learning builds upon contextual situations – the being of nursing.
In contrast to traditional nursing behavioral pedagogy, constructivist pedagogy subscribes to authentic experiences for learning. Constructivist pedagogy is learning as an active, subjective process that builds from personal experiences (Peters, 2000). Constructivist pedagogy, or constructivism, was initially defined by Vygotsky (1926/1997) as a theory describing the learner as a constructor of knowledge who actively searches for meaning in transactional, socially-constructed situations. To apply constructivist pedagogy to nursing education, students are not to be observed behaviorally by the nursing instructor as a skill is performed; students are to engage actively in being in a nursing setting. The student will interact with the instructor to understand the meaning of the experiences of interacting with a patient. Constructivism would therefore provide an adult learning framework for self-directed learning in a socio-cultural environment of a clinical nursing setting (Peters, 2000). In a constructivist pedagogy, student nurses could learn how to be a nurse in the clinical setting – intertwining the art and science of nursing with the instructor as the mentor/teacher.

To understand the development of the being of nursing, particularly to understand the experiences, the authenticity of the nurse/patient interactions, nurse educators must know student nurses’ descriptions of these experiences to identify how student nurses experience nurse/patient interactions. In particular, nurse educators need to understand how student nurses make meaning of their early experiences in nurse/patient interactions in order to enhance development of the “being” of nursing. Constructivist thinking identifies that students
discover and construct meaning from active experiences where they make sense from what they already know and build upon background knowledge. Heidegger (1962/1999) would subscribe to student nurses learning nursing from being-in-the-world of patient care, or nursing practice. Benner (1985) argued that “though the meanings available to the individual can undergo transformations, they are limited by a particular language, culture, and history” (p. 306). If nurse educators do not understand how students make meaning of early experiences, educators will not know how to enhance optimum learning. The key to assisting nursing students in developing the being of nursing is to understand how the students begin to experience nurse/patient interactions. The authentic nurse/patient interactions in the clinical setting are where opportunities are created for learning the being of nursing, the intertwining of the art and science of nursing. Being and presence intertwine as student nurses interact with patients. This introduction leads to a statement of the problem: Nurse educators do not know or understand how student nurses make meaning of experiences of “being” in nurse/patient interactions of nursing.

As a nursing educator, I am concerned with how students learn to be with a patient. Because the nurse/patient interaction is such a vital part of nursing, the nurse/patient interaction is, at the deepest level, a sacred space. Authentic nurse patient interactions occur only in the clinical setting, where being and presence intertwine. The purpose of this research is to understand how student nurses make meaning of experiences of “being” in nurse/patient interactions. The research questions of this study are:
1. What is the meaning student nurses make of their experiences in nurse/patient interactions?

2. How do student nurses experience the various levels of presence in nurse/patient interactions? (see presence in the literature review)

3. How do nursing students describe being in their nurse/patient interaction?

The research presented here was a qualitative study involving student nurses in journal writing. The student nurse participants who attend a traditional, Midwestern university school of nursing described the experiences of their interactions with patients through journals. The experiences of students as they describe their interactions with patients, as well as how the students make meaning of the interactions, are keys to understanding the development of the being of nursing.

Significance of the Research

Chinn (1994) identified the art of nursing as the aesthetic knowing of nursing. Chinn suggested the art of nursing occurs in nurse/patient interactions in which apprehension of the meaning of a moment occurs without cognitive awareness. An instantaneous grasp of the situation and a simultaneous knowing call forth something from deep within the nurse. When such an artistic moment occurs, it is distinct from any sense of empathic understanding. (p. 36)

Chinn continued to describe these artistic nursing moments, or aesthetic nursing, as meaning formed from experience. Chinn stated the art of nursing is not learned from “reasoned, systematic, linear, problem-solving modes of thinking or action” but from “an embodied grasp of situations and intimate experience with the deepest and most significant life events” (p. 37). The art of
nursing must be learned from experiences in practice. Nelms (1996) stated the essence of nursing is in the *being* and doing of nursing. The practice of nursing is where the art and science of nursing come together to make meaning of the experiences of nursing.

Benner (1984) identified nursing practice as an integrated art and science that is demonstrated as competent or expert only through being in practice as a nurse and learning through constructive experiences over time. Benner stated nursing practice is far more than performing skills, or understanding and applying nursing content or theories. Chinn (2001) identified that nursing is more than technical or interpersonal skills, but is a holistic, integrated healing art. Chinn defined nursing as complex actions and interactions (nursing skills and nurse/patient interactions) in the unitary, coherent whole of the art and acts of nursing (the intertwining of the art and science of nursing). Newman (2002) proposed nursing knowledge is a holarchy, rather than a hierarchy of learning. A holarchial progression of nursing knowledge means nursing moved the emphasis on physical care to an interpersonal process, to an integrative approach, to a unitary perspective. Each succeeding level transcends and includes the previous levels in a holarchy, according to Newman. Therefore, nursing practice is clearly a holistic meeting or intertwining of the art and science of nursing.

In contrast to the holism of nursing practice, Doane (2002) contended that nursing education breaks the practice of nursing apart. Doane identified that nursing students are taught the knowledge and skills of nursing based upon curricular and pedagogical beliefs that are scientific and outcome focused. Doane
contrasted that nursing students are taught how to interact with patients through behavioral communication skills with each other in classroom or laboratory settings using behavioral outcomes. These behavioral communication skills are the methodology nurse educators have employed to assist student nurses to learn how to interact with patients. Doane suggested that behavioral communication skills are not effective in helping students learn to experience the shared space of the nurse patient relationship. Doane recommended student nurses have more experiences with patients and then have discussions with instructors to learn how to better experience the being of nursing.

Through the research and knowledge of these nursing leaders, nursing practice and nursing expertise has clearly been defined as an integration of the art and science of nursing. Nursing education has been so focused upon scientific and theoretical outcomes that the art of nursing has been assumed to be part of clinical experiences or learned in behavioral skills laboratories. The significance of the research presented here is the importance for nursing educators to understand how students learn how to be, the being in nurse/patient interactions. To understand how students learn to be in nursing will be a significant aspect of designing curricula in nursing education and learning outcomes specific for nursing education. Nurse educators need to know the student perspectives in order to design curricula with outcomes that allow the art and science of nursing to be experienced and identified.

Peters (2000) contended that traditional behaviorist pedagogy, with content and teacher-focused knowledge, is not in congruence with nurses and
nursing practice. Chinn (2001), Newman (2002), and Watson (2001a, 2001b) suggested that nursing must merge practice, research, and education as a unitary knowledge. Peters suggested that constructivist learning offers great potential for enhancing self-directed learning of new students to nursing, and is more congruent with the transition from nursing education to nursing practice. If nursing education is going to change from the traditional behaviorist pedagogy to the constructivist learning pedagogy, then nurse educators must understand how student nurses begin to experience the nurse patient interactions, to create a framework and curriculum that enhances optimum learning. Nursing education must become open to student nurse learners and to the arena of nursing practice to provide the best education for students to construct the art and science of nursing practice.

Assumptions

There were several assumptions associated with this study.

1. The participants were honest and truthful in their comments in both verbal and written form.

2. The participants related/recalled experiences in the nurse/patient interactions accurately and as the individual experiences actually occurred.

3. The student nurses participated freely, willingly, and without coersion in the research.

4. The participants chose to explore more fully their thoughts and experiences about nurse/patient interactions.
5. The experiences shared by the student nurses of nurse/patient interactions provided correct and accurate identification of how student nurses make meaning of the interactions.

**Limitations**

There were several limitations from this research.

1. The backgrounds and previous life experiences of the student nurse participants are individualized and may have affected how the student nurses made meaning of the nurse/patient interactions.

2. The maturity of the individual participants may have affected the nurse/patient interactions.

3. The nurse/patient interactions are unique and not necessarily comparable as experiences nor as perceived by each student.

4. The researcher has a bias and will be aware of this bias in the data collection and analysis of the data.

5. The outcome of this research was not to generalize the results.

**Definitions**

*Art of nursing.* The art/act of the experience-in-the-moment; the creative caring of the nurse in interaction with the patient; created from the humanness of an interaction of a nurse with a patient (Chinn, 1994).

*Authentic.* To be genuine, real; actually present in an experience or interaction (Paterson & Zderad, 1976).

*Being.* A process or activity of existing; not an entity to be defined. The only way to understand being is to discover the meaning of being. Being is
looking back at an experience that has occurred to fully understand the process (Gelven, 1970).

Caring. An essential human interaction expressed in nursing by how the nurse delivers the skills and knowledge of nursing with a patient (Noddings, 1984).

Constructivist pedagogy. A learning that occurs not from discovering or finding knowledge but by constructing knowledge. Constructivist pedagogy allows students to form or make knowledge, to make sense of experiences, and to continually test and modify these constructions in each new experience (Schwandt, 2000).

Curriculum. The interactions and transactions that occur between and among students and teachers with the intent that learning occur. (Bevis, 1989).

Dasein. To be – to experience or inquire into one’s being with the world (Heidegger, 1962).

Meaning. Meaning is what feelings, thoughts, and perceptions an individual has in an experience. Meaning is the organization of what happens to an individual; it is to make sense of what happens (Benner & Wrubel, 1989).

Nursing. The diagnosis and treatment of actual or potential health problems (American Nurses’ Association, 1995).

Nursing students. College students who are majoring in nursing and who are enrolled in classes in the nursing major. The students are participating in clinical experiences.
Nurse/patient interaction. A nurse bringing her knowledge, skills, and values into a relational experience with a patient to achieve a mutually determined goal to work toward health of the patient (O’ Brien, 2003).

Nursing educator. A registered nurse with a minimum of a master’s degree in nursing who teaches nursing to undergraduate college students in the clinical and/or classroom setting.

Nursing pedagogy. An organized curricular system of learning nursing in colleges and universities. Nursing pedagogy incorporates conceptual frameworks that organize nursing education around concepts, facts, propositions, postulates, phenomena, theories, and variables of a specified model or theory of nursing (McEwen & Brown, 2002).

Nursing theory. An organized framework of concepts and purposes designed to guide the practice of nursing. Nursing theories predict occurrences and changes in chemical and biological events, and identify frameworks for nursing actions to intervene in the predicted events (O’Brien, 2001).

Presence. The physical and psychological being of the nurse with the patient to meet the patient’s health care needs (Gardner, 1985).

Sacred space. The special interaction and sharing between the nurse and patient in a unique transcendent presence of interpersonal knowledge (O’Brien, 1999).

Science of nursing. The knowledge, content, skills, and interventions of nursing.
To be with. To experience an interaction with another human being; to be authentic; to be experiencing presence in an interaction with another human being (Paterson & Zderad, 1976).

Conclusion

While I researched the background for this research, one of my senior nursing students submitted a journal entry of an emergency room (ER) clinical experience. This journal entry, while a required exercise for the student, eloquently expresses his experience of a nurse/patient interaction. The patient had arrived at the ER complaining of chest pain after an automobile accident. The patient had a collapsed lung, and was prepared to have a chest tube placed into her chest cavity. The student was honored that the patient allowed him to be present while the chest tube was placed. The student described holding the patient’s hand and talking to her about non-pertinent information. The student then stated:

For me, the best moment of interaction took place when the patient looked directly into my eyes as she was beginning to cry from the pain. It was an indescribable feeling. It was as if I was the one having the procedure performed and she was merely watching from a corner. Some might even call it “spooky.” I guess it’s just one of those things that happen. You can’t explain it well but you just know you felt something unique. (JH, personal communication, April 20, 2003)

This journal entry is an example of a student nurse experiencing being in a nurse patient interaction. The student clearly experienced far more than the science of understanding a collapsed lung and assisting a physician in the skill of placing a chest tube. The student experienced the art of nursing in being and presence, even sharing sacred space with the patient. Neither reading an example of this experience, nor practicing an experience in a behavioral skills laboratory
would come close to the personal experience this student shared with this patient. The learning outcomes of the art of nursing are most appropriately learned through real life experiences and cannot be simulated. Moccia (1988) stated meaning occurs in the shared moment of authenticity between patient and nurse and the meaning flows from the space the patient and nurse share. This dissertation attempts to answer the research questions into the *being* and presence of nursing as experienced by nursing students.
Chapter Two

Literature Review

Nursing is an art, and if it is to be made an art, it requires an exclusive devotion, as hard a preparation, as any painter’s or sculptor’s work. For what is having to do with dead canvas or cold marble compared with having to do with the living body, the temple of God’s spirit. (Florence Nightingale, 1969)

In this chapter, a thorough background of the history of nursing practice and nursing education is discussed. The art and science of nursing, the art of nursing, and the science of nursing are defined and discussed. The elements of the art of nursing – caring, presence, sacred space, and being are identified and examples are explored. Finally, the pedagogy of nursing education is discussed from an historical perspective. The traditional pedagogical usage of behavioral objectives and the more creative use of constructivism and Narrative Pedagogy are defined and explored.

Background

The profession of nursing has developed and changed dramatically over the past two centuries. Nursing began as an art, or genuine caring, by women who nursed people who were sick. Florence Nightingale is credited as the founder of nursing in the 1850s during the Crimean War in Europe; however, nursing care is documented far earlier than that time. Nursing was practiced in ancient civilizations based on archeological findings in Babylonia, Egypt, Greece, Rome,
China, India, and Israel (O’Brien, 1999). The word nursing is derived from the Latin word *nutrio*, or to nurture. Nursing at those times was simply care given to “the helpless, the old, the young, the sick, or the injured” (Sellew & Nuesse, 1946, p. 13). In the early Christian church, caring for the sick and injured was an honor. In the Bible, Jesus Christ provided examples of how to care for the sick through His ministry of healing and teaching. For many years, those who cared for the sick were deacons and deaconesses, matrons, sisters, and monks. Many religious orders were founded by women whose primary beliefs were founded upon Jesus’ teachings to care for the sick (O’Brien, 1999).

As early as the late 1700s, hospitals were staffed by women who cared for the sick and who were called nurses. These women primarily provided bedside nursing as a mother would provide care to a child – by meeting basic life needs, including comfort and cleanliness. The first organized instruction for nurses began in 1798, when Dr. Valentine Seaman taught classes for nurses at New York Hospital. Dr. Seaman offered a series of 24 lectures that included a variety of topics including anatomy, care of children, and midwifery (Boschma, 1994). The first known school of nursing was in England in the early 1800s, where the Protestant Sisters of Charity organized an eight-week education for nurses. These Sisters, as well as several other orders of Sisters in Ireland and England, followed the education or training period with uniforms, pay, and housing for the nurses at the hospital (Palmer, 1985).

Beginning in 1854, Nightingale and her nursing colleagues cared for men who were injured while fighting in the Crimean War. The nurses worked in field
hospitals providing primarily physical nursing care to the injured men. Nightingale is known for setting environmental standards and improving bedside care for the sick and injured men at this time. Nightingale (1859/1969) also believed nursing was a higher calling for women, and she believed nursing should be taught in training programs within a female hierarchy that would be disciplined in moral and maternal characteristics. Nightingale believed that nurses were present to help the sick and injured to health, and that “fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet were keys for nurses to aid patients’ return to health” (p. 8). Nightingale claimed that nursing “seems to be expressly constituted to unmake what God had made disease to be; a reparative process” (p. 9).

Nightingale was the first educator to have a major impact on nursing based upon her research of care in various hospitals across Europe. Nightingale originated a school of nursing at St. Thomas Hospital in London, England in 1860, which is described in detail by Palmer (1985) and by Sellew and Nuesse (1946). The education in Nightingale’s school of nursing was practical and mostly hands-on training – the artful caring interactions of nurses with patients. Nightingale also became known for her writing. She wrote a famous series of *Letters to Nurses and Probationers* (her term for student nurses) in 1872, which discussed her beliefs; the values and goodness of the spirituality of nursing; and the importance of morality, humility, and continued learning to nursing (Palmer, 1985). In her *Letters to Nurses*, Nightingale (1915) called nursing “the finest of the fine arts” (p. 1). All of
these examples of Nightingale’s beliefs and influences on the development of nursing are why she is famously known as the founder of nursing.

The movement of nursing from an art to include science began in 1873. That year, the first instructor of nursing, called a “Home Sister” was appointed at the Nightingale School. In addition to hands-on training, the nurse probationers attended lectures and had prescribed study periods. The influence of science started to develop during this era (Doheny et al., 1997). At this same time, a surgeon, Dr. John Croft, began instructing the probationers in the knowledge and skills he wanted the nurses to possess (e.g., anatomy, cleanliness, bandaging, pharmacology, and chemistry). The focus of nursing changed from only a desire or calling to care for the sick, to also include formal education in caring for the sick. The simple art of caring was not enough to overcome illness and disease – the science of skill and knowledge became important (Doheny et al.).

In the United States, the evolution of nursing paralleled Nightingale’s system in England. Women in America provided nursing care for injured men during the Civil War (Doheny et al., 1997). Clara Barton and Dorothea Dix were two nurse leaders who were instrumental in directing nursing care for the soldiers. After the Civil War, nurses moved into hospitals to provide care to the sick. During the post-Civil War era, formal nursing education started in New York and Boston in hospital-based schools of nursing, and the education was modeled after the Nightingale system in England (Sellew & Nuesse, 1946).

The education of nurses first moved to a university setting in the 1900s, in conjunction with Teachers’ College of Columbia University. For the first time,
nursing education encompassed more than just how to care for the sick and injured. Adelaide Nutting, a nurse from the Johns Hopkins Hospital School of Nursing, became the first professor of nursing at Teachers’ College (Doheny et al., 1997). Nursing education began to focus on health and on the prevention of illness, and began to move out of the hospital classrooms into separate schools of nursing (Doheny et al.). Nursing students began living next to the hospital in nursing dormitories, where classroom education also occurred. Nurses attended new classes focusing on diet, hygiene, and healthy habits, and were taught prevention of illness in the many immigrants and current residents of the United States. Annie Goodrich, Dean of the Yale University School of Nursing, stated in 1932 that nurses should focus on health education and lifestyle improvement in every patient encounter, wherever the encounter occurred (Boschma, 1994). Despite a change of focus in nursing to include the health maintenance of patients, most nursing care remained in hospitals.

Until the 1950s, the primary training and education of nurses remained in hospital-based schools of nursing. Reverby (1987) described the lives of student nurses at this point in nursing education. Many of the hospital-based schools of nursing were founded and administered by religious orders. Student nurses lived in dormitories attached to the hospital, and often were required to work in the hospital after clinical and classroom hours were completed. The student nurses had little free time and were immersed in the nursing education experiences. Education was based upon authoritarian training that was task and routine-oriented. The
functional, task, and routine-oriented training incorporated both the art and science of nursing.

After World War II, nursing leaders began to redefine the role of the nurse. As nursing education continued to move from hospital programs to universities, the focus of nursing continued to move toward the science of nursing (Reverby, 1987). Through research and scientific methods, nursing began to identify specific patient problems that nurses could assist the patient to resolve. Thus, nursing changed from the art of caring in the apprenticeship system of hospital-based schools, to a focus on the science of nursing in the academic setting of universities. The art of nursing was still present; but the science of nursing became the main focus for learning in the college environment.

Boschma (1994) described how the university setting changed the overall education of nurses in both the learning environment and the living lifestyle. The requirements of a four-year baccalaureate degree included general education courses such as basic science courses, fine arts, and foreign languages. Nursing students began living on college campuses, for at least some of the college experience, and interacted with students of other disciplines. The college campus lifestyle differed completely from the nursing dormitory lifestyle. Nursing students no longer lived and worked in a hospital environment, but experienced life on a college campus. Typically, nursing education in colleges allowed for one to two years of the general education courses, with the last two to three years dedicated solely to the nursing classroom and clinical experiences. Student nurses were still
immersed in the nursing environment; however, the classroom and life experiences were congruent with a traditional college education.

The baccalaureate nursing education was different from the task and routine-oriented nursing education of the hospital schools of nursing. Nurses educated in universities were required to develop knowledge and skills through scientific inquiry (Chinn, 1994). Nurses were to focus “on health-seeking behaviors and the patient’s response to illness and disease” (Boschma, 1994, p. 328). Nursing changed from a focus on training in how to “do” nursing, to a focus on thinking. Therefore, nursing changed from a focus on both the art and science of nursing to a focus primarily on the science of nursing.

As the thinking and practice of nursing changed to a focus on science, nurses became problem solvers in providing care. Nursing became structured similarly to medicine. The nurse was no longer just artfully caring for patient needs through tasks, but was an objective problem-solver who focused on outcomes of care delivery. O’Brien (1999) gave an example of a nurse as a problem solver - a nurse no longer just gave water to a thirsty patient (saw a need and responded), but looked for reasons the patient was thirsty (identified a problem), decided what to do about the thirst (solved the problem), and then decided if what was done was effective (was an outcome achieved?). Growth in nursing theory development occurred due to this change of focus in the nursing profession from the 1950s to the 1980s (O’Brien). The science of nursing was defined during this era in nursing.

In the 1950s, the term “nursing science” began to be used in the nursing literature. Nursing science defined the profession of nursing as “systematically
organized into general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing” (Carper, 1978, p. 13). Nurse leaders believed the only manner in which to advance the profession of nursing was to define clearly the science of nursing. Over the next 20 years, multiple theories of nursing were developed that attempted to quantify and organize nursing into a distinct science. These nursing theories ranged from simple descriptive models that described and classified natural phenomena that are seen by direct inspection and observation, to detailed, abstract models that looked at adaptation of a person’s health on a continuum of health to illness (Carper).

Nursing attempted to objectify the profession through these years of theory development, and in many ways the profession became more diverse due to the many theories of nursing that were identified and developed. Another factor that contributed to the increased diversity in nursing was the addition of the two-year associate degree, or community college nursing programs. Nurses were needed in greater and greater numbers due to a growth in population and health care needs, and the associate nursing degree provided educated nurses in two years. The associate degree nursing programs provided a task-oriented, technical education that functioned to generate nurses in a shorter time frame than the hospital-based or baccalaureate programs. Simultaneously, the three-year hospital based schools of nursing and the four-year baccalaureate schools of nursing continued to educate nurses.

The philosophies and curricula in these three educational preparation programs of nursing vary greatly. The two-year and three-year degree programs are
technical, focusing on skill acquisition. Students are taught by baccalaureate or master’s degree prepared nurses, called instructors, who teach the skills of nursing (e.g., how to make beds, give medications, start IVs, measure and record vital signs). The four-year nursing degree is a baccalaureate degree, incorporating a liberal arts and science background with the skills acquisition of a nursing education. A baccalaureate degree further prepares a student to be a nurse who can critically think, make meaning of diverse experiences, and learn from professors who are at the highest level of knowledge attainment (Boland & Finke, 2005). Due to the three different nursing education programs, there is diversity of nurses within the profession.

In the 1980s, as health care delivery changed to a faster-paced, technological focus, nursing started to change again. The art of nursing started to return to balance the science of nursing. Nursing returned to a person-centered approach, while still incorporating the problem-centered, scientific viewpoint (Chinn, 1994). Humanistic nursing theories developed during these years, with a focus on the interactions of the nurse with the patient (Watson, 1988). The art of nursing has richly developed since the 1980s due to these new nursing theories centering on the art of nursing. These nursing theories focused on the unity of the mind and body, and upon the uniqueness of the human experience over time (Chinn, 1994; Leininger, 1988; Watson, 1988).

Currently, nursing is defined as both an art and a science, and nursing care is provided to individuals, families, groups, and communities in any variety of settings including hospitals, schools, clinics, churches, long-term care facilities, and the
home. The art and science of nursing intertwine to define nursing practice. Today, nursing education is primarily located in institutions of higher education. The teachers of nurses today are nursing educators - professors of nursing with doctorates of philosophy in nursing or other closely aligned disciplines (Ruby, 1999).

In summary, nursing began as an art, evolved to focus on science, and today is an intertwining of art and science. In the beginning of the history of nursing, nursing was simply caring for someone who was ill by nurturing the person back to health. Nursing evolved to include an expertise of skills and knowledge, well supported with scientific nursing theories. In the 21st century, nursing has become a holistic, caring discipline supported by all the skills and knowledge from educated nurse professionals. The art and science of nursing have certainly evolved, yet both art and science have remained woven through the history of the profession (Doheny et al., 1997).

The Art and Science of Nursing

Paterson and Zderad (1976) describe nursing as “an experience lived between human beings” (p. 3). This perspective suggests nursing is an application of the science of nursing into each individual, authentic, nurse/patient interaction. In this description, as in nursing, the art and science of nursing intertwine. The art and science of nursing become intertwined as an individual nurse develops expertise from repeated interactions over time to define his/her personal knowledge and expertise in nursing. Paterson and Zderad (1976), and Benner, Tanner, and Chelsa (1992) have identified that nursing has evolved as a discipline because
nurses continually develop knowledge and expertise through nursing practice. An expert nurse who understands the practice of nursing incorporates the art and science of nursing simultaneously. Benner et al. stated “But the nurse, who is an expert in caring, knows that he or she cannot be guided by principles or any pseudosciences of the psyche, but must enter into the situation of the patient and be guided by participation and intuition” (p. 47). These nurse experts relate expertise in nursing to driving a car to work. Once an individual has learned the rational, linear steps to driving, the act occurs without conscious deliberation. An expert nurse has learned the science of nursing through nursing education, and the repeated interactions with various patients allows for the art of nursing to be incorporated into the nurse’s practice and way of being (Benner et al.).

Carper (1978) suggested nursing knowledge consists of four fundamental patterns of knowing: empirics, esthetics, personal knowledge, and ethics. Empirics, or the science of nursing, is a systematically organized knowledge controlled by factual evidence of laws and theories that describe, explain, and predict phenomena of nursing. Esthetics is the art of nursing - a creative, expressive, subjective, and unique experience with a unity between the action and the result. Personal knowledge is the knowing, encountering, and actualizing of the individuals in the nursing experience. Ethics is the pattern of knowing that is focused on matters of obligation, or the judgment of right and wrong. Carper uses the four patterns of knowing for awareness of the complexity and diversity of nursing knowledge. Empirics is a pattern to describe the science of nursing - esthetics, personal knowledge, and ethics are patterns to describe the art of nursing. All four patterns,
representing both art and science, are interrelated processes that define the whole of knowing in nursing (Chinn & Kramer, 1995).

Donahue and Stewart are two nurses who describe the intertwining of the art and science in nursing. Donahue (1985) beautifully describes the interactions of art and science in nursing. She identifies science as a linear, static concept that makes nursing a highly skilled trade. Donahue identifies the art as an active, dynamic, developing concept that involves emotion and intellect. The science of nursing stresses the role of intelligence or thinking; the emotional quality guides the transformation of the actions of science into art. Hence, art and science intertwine.

Another nurse known for descriptions of the art and science of nursing is Isabel M. Stewart (1985), who wrote in 1929 that the highly skilled trade (science) of being a nurse was nothing without the true artist of the nurse. Stewart stated:

The real essence of nursing, as of any fine art, lies not in the mechanical details of execution, nor yet in the dexterity of the performer, but in the creative imagination, the sensitive spirit, and the intelligent understanding lying back of these techniques and skills. Without these, nursing may become a highly skilled trade, but it cannot be a profession or a fine art. All the rituals and ceremonials which our modern worship of efficiency may devise, and all our elaborate scientific equipment will not save us if the intellectual and spiritual elements in our art are subordinated to the mechanical, and if the means come to be regarded as more important than ends. (p. 1)

Stewart (1929/1985) described nursing from an esthetic viewpoint. In an article written from a similar esthetic viewpoint, Gendron (1994) compared nursing practice to the art of weaving a tapestry. A tapestry is woven on a loom, and the loom has two elements called the warp and the weft. The warp is composed of the bare strings that are the foundation of the tapestry. The weft consists of the threads that are woven across the warp strings, creating the image of the tapestry. Gendron
compared the warp in a tapestry to nursing science – the foundation of nursing. In
the analogy, the weft becomes the artistic care that the nurse creates in the
nurse/patient interaction. Gendron believed that as the warp and weft are woven to
create a tapestry, a nurse weaves science and art in practice to care for a patient.

In order to understand the concepts and terminology that make up the art
and science of nursing, several nursing elements are described in the next six
sections. The six elements discussed are the science of nursing, the art of nursing,
caring, presence, sacred space, and being.

_The Science of Nursing_

The science of nursing is based upon skill acquisition and the content
knowledge, or theoretical knowledge of nursing (Donahue, 1985; O’Brien, 2001).
Giving injections, performing assessments, and changing dressings, for example,
are taught as key skills in nursing practice. Medications, nursing interventions for
certain patient problems, and various disease signs and symptoms are taught as
content knowledge for nursing practice. The expertise and knowledge learned from
nursing practice has lead to the development of nursing theories, another important
part of the science of nursing. O’Brien discussed how nursing theories are derived
from the scientific knowledge of medicine, chemistry, and biology, and have also
evolved from experience in nursing practice. Nursing theories predict occurrences
and changes in chemical and biological events, and identify frameworks for nursing
actions to intervene in the predicted events. Nursing theories also provide the
framework for the content and process taught in nursing programs (O’Brien).
The science of nursing is taught in nursing education through content in the classroom and through skills performed by students in a laboratory and clinical setting. The curricular frameworks of nursing education are based upon nursing theories (Boland & Finke, 2005). The learning of the content is measured through achievement of behavioral objectives set by the nurse educators. Traditional ways of measuring behavioral objectives on content are examinations on classroom and textbook content, and written nursing care plans or care maps on clinical experiences. The behavioral objectives are the outcomes that recognize the characteristics that students should achieve at a set time in the curriculum (Boland & Finke). The student must successfully demonstrate step-by-step performance of a skill to indicate learning the skill (e.g., a student successfully starts an IV by performing the individual steps required). Student nurses must first perform skill acquisitions, or competencies, in laboratory settings on mannequins and then the skills are performed with patients (Boland & Finke). Research on content learning and skill acquisition in student nurses has been well reported in the literature and is faculty-driven (Becker & Neuwirth, 2002; Clayton et al., 1989; Ferguson & Calder, 1993; Olson et al., 1984; Robbins, 1999; Scheetz, 1989; Schwerian, 1978). The research for content learning has focused on ways to improve and measure critical thinking and assist students in problem solving from the faculty perspective (Gendrop & Eisenhauer, 1996; Haffer & Raigruber, 1998; Myrick, 2002; Nehls et al., 1997; Patterson, Crooks, & Lunyk-Child, 2002; Peters, 2000; Youngblood & Beitz, 2001).
The focus on skill acquisition in nursing students was especially important in the 1960s through the 1980s (O’Brien, 1999). The increase in technology during those years stimulated the nursing profession to adjust to the changing clinical climate. Even with all the technological change in health care, the methodology of nursing students learning to acquire skills did not proportionally change across time. Student nurses learn skills in a laboratory setting, and then enter a hospital where skills are performed on patients with a nurse instructor present for guidance and support. Benner (1982, 1984) has researched and published extensively on the skills acquisition in nursing after nurses graduate from formal education and begin practice in nursing. Benner (1984) derives her theory of skills acquisition from nurses in practice, and identifies five levels of proficiency. Skills acquisition is a combination of “knowing that” (the science) and “knowing how” (the practice of nursing) - the doing - according to Benner (1984, p. 2). The “knowing that” – the science – is the education, knowledge, and content of nursing. The “knowing how” – the practice of nursing – is the experience/expertise, skills, and interventions of nursing. Throughout her extensive research, Benner has further defined nursing practice and the development of nursing expertise.

Historically, the science of nursing has elevated the discipline of nursing to a respected profession through continual discovery and revision of nursing theories. The science of nursing has been clearly defined and measured, and continues to be researched extensively by nurse scientists.

*The Art of Nursing*
The art of nursing is not as easily described, identified, or understood as the science of nursing. An abundance of literature exists concerning the art of nursing and the writings are quite diverse. A recurring theme throughout the literature is that the art of nursing is found in the experience of the interaction between a nurse and a patient. Chinn (1994) states the “art of nursing is the art/act of the experience-in-the-moment” (p. 24). Art occurs from being in the interaction – the nurse is the artist working with the patient in the nurse/patient interaction.

“Nursing, like dance or painting, is not an art of the written word. It’s partly kinesthetic – transmitted in facial expressions, touch, gestures, timing, intent” (Mallison, 1993, p. 7).

The art of nursing was further described by Johnson (1996) as “often associated with creative and intuitive activities” (p. 169). The art of nursing is the creative caring of the nurse in interaction with the patient. While science has linearity and theory defining the practice of nursing, the art of nursing develops from the humanness of the nurse and patient (Osterman & Schwartz-Barcott, 1996; Paterson & Zderad, 1976). Art is created differently in each nurse/patient interaction.

Traditionally, the art of nursing is taught in schools of nursing through communication lectures or in behavioral communication skills laboratories (Doane, 2002). The art of nursing is taught as part of the “hidden curriculum – the curriculum of subtle socialization, of teaching student nurses how to think and feel like nurses” (Bevis, 1989, p. 75). However, since the true art of nursing only occurs from humanness – the actual interaction of the nurse and the patient – Doane
believes the communication skills laboratories do not allow students to accurately learn the art of nursing. The art of nursing occurs because nurses dwell with their patients in the human realm. A nurse interacts with a patient to understand his/her feelings, needs, emotions, and concerns of health and illness in an individualized, personal manner. This is the art of nursing – a nurse in relationship with or being with a patient. The essential core, the heart of nursing, is the nurse/patient interaction. The interaction of the nurse with a patient is the place where the nurse experiences nursing (Appleton, 1994; O’Brien, 2001; Chinn & Watson, 1994; Johnson, 1994).

A nurse/patient interaction is a very special interaction, unlike any other human encounter. The nurse/patient interaction, also identified as the nurse-patient relationship, is the foundation of nursing care (Peplau, 1952). Haggerty and Patusky (2003) identified the nurse-patient relationship as an interpersonal process that develops over time between the patient and the nurse. The terms nurse/patient interaction and nurse/patient relationship are used interchangeably; however, there are distinctions between the terms. Morse, Havens, and Wilson (1997) define the nurse/patient interaction as a snapshot, or a scene without considering the history or outcomes of either the patient or nurse. The nurse/patient relationship is the patient and nurse in a snapshot that occurs due to repeated interactions, where history and some outcomes have already been established. For purposes of this study, the term nurse/patient interaction is more appropriate. The art and science of nursing are woven together in a nurse/patient interaction. In a nurse/patient interaction, the
element of caring becomes the concept that intertwines the art and science of nursing.

Caring

Caring is an element that intertwines the art and science of nursing in the nurse/patient interaction. The concept of caring has been associated with nursing since the beginning of human interaction in ancient Babylonia. One human being can reach out to another human being through caring for and about that person. Caring means “being connected and having things matter” (p. 1) and “is essential to nursing practice” (p. 1) according to Benner and Wrubel (1989). Caring is the “expression of our humanity” (p. 8) and caring is “essential to our development and fulfillment as human beings” (p. 8) according to Roach (1991). Although caring is not unique to nursing, caring is a very important element of nursing. Leininger (1978) defined caring in nursing as:

- direct (or indirect) nurturant and skillful activities, processes and decisions related to assisting people in such a manner that reflects behavior attributes which are empathetic, supportive, compassionate, protective succorant, educational and otherwise dependent upon the needs, problems, values and goals of the individual or group being assisted. (p. 489)

The nurse steps out of his/her situation to focus on the cared-for, the patient. “The commitment to act in behalf of the cared-for, a continued interest in his reality throughout the appropriate time span, and the continual renewal of commitment over this span of time are the essential elements of caring” (Noddings, 1984, p. 26). To care is not to act by set rules (science), but to act with affection and regard (art). Nelms (1996) discussed the meaning of caring in her hermeneutic study of nurses in practice. One of the participants stated, “Caring is something you give and receive.
Caring makes your understanding richer and deeper. All of the mechanical, scientific technology may save lives, but it doesn’t create bonds. Caring does” (p. 373). Leininger (1988) believes “Care is the essence of nursing and the central, dominant, and unifying feature of nursing” (p. 152).

Carper (1978) described conscious caring through four patterns of knowing, discussed earlier in the art and science of nursing section. Each level or pattern of knowing becomes deeper in the understanding and sharing of a nurse with a patient, becoming more authentic and involving more presence of the nurse with the patient. Throughout the nursing literature, caring is the concept that reoccurs many times, and is always described as the human interaction, or way of being, with a nurse and a patient. Caring allows the art and science to intertwine to create nursing. The nurse is present with the patient in acts of caring in nursing.

**Presence**

In order to physically care for someone, a person must be present to another person. The caring that intertwines the art and science of nursing requires the element of presence between nurse and patient. Presence is defined as “an intense and intersubjective reality that changes the participants and has permanence” (Doona, Haggerty, & Chase, 1997, p. 5). Gardner (1985) defined presence as the “nurse’s physical being there and the psychological being with a patient for the purpose of meeting the patient’s health care needs” (p. 317). Gilje (1992) elaborated on being there and being with the patient in presence. In an example of being there, a nurse is physically present to the patient – perhaps checking the respiratory rate and depth of a patient waking from anesthesia. Being with, a
psychological presence, occurs when the nurse talks with the patient later in the shift to assess the patient’s pain, or to comfort the patient as the patient shares sadness over loss of function from the surgery. In being with, the patient shares self disclosure and the nurse returns compassion.

Paterson and Zderad (1976) described presence in several ways, calling nursing presence pivotal in the nurse-patient relationship, and identifying presence as both personal and professional. The personal presence is the physical, individual being of the nurse; the professional presence is the goal-directed, accountable interaction of the nurse. A nurse demonstrates presence by being there with a patient, not by objectifying the patient, but by experiencing responsibility or regard for a patient’s vulnerability as a person. Appleton (1994) identified the nurse as “the gift of self” and defined nursing as an intimate relationship of a nurse with a patient where the nurse gives of herself/himself in caring for the patient. Appleton stated “the nurse comes to know the patient and the two co-create a way of helping that can make a difference in the patient’s life” (p. 110).

McKivergin and Daubenmire (1994) defined three levels of presence in nursing practice – physical presence, psychological presence, and therapeutic presence. Physical presence was defined as the nurse’s being there for the patient, performing nursing interventions and routine tasks. The physical body of the nurse is seeing, examining, touching, or hearing the physical body of the patient at this level of presence. Psychological presence was identified as being with the patient mind to mind – the nurse using self to assess, communicate, care for, comfort, help, or support the patient. The last level, therapeutic presence, occurred when the nurse
relates to the patient as “whole being to whole being” (pp. 69-70), using all the nurse’s resources of body, mind, emotions, and spirit. McKivergin and Daubenmire identified that only experienced nurses usually reach therapeutic presence, but suggested nursing education could teach student nurses how to identify and achieve therapeutic presence.

In comparison to McKivergin and Daubenmire, another pair of nurse researchers defined levels of presence in a different manner. Osterman and Schwartz-Barcott (1996) discussed presence between a nurse and patient through detailed descriptions of nurse/patient interactions and defined each level as a more involved and intimate sharing between a nurse and a patient. Osterman and Schwartz-Barcott defined presence as the nurse “being there” for the patient. The four levels of presence were presence, partial presence, full presence, and transcendent presence.

Presence was identified by Osterman and Schwartz-Barcott (1996) as the nurse being physically in the room with the patient with no other interaction occurring. Partial presence was defined as the nurse being there with the patient but also performing a physical skill – for example, checking the infusion of the intravenous medication. Full presence was identified as the nurse being physically and psychologically present with the patient. Full presence occurs when the nurse is fully open to the patient and performs intentional acts of care. Transcendent presence was defined as more abstract and elusive, an intimate, transforming, and spiritual sharing between the nurse and patient. In transcendent presence, the sharing is a connectedness between a nurse and patient that potentially extends
beyond the two people to be felt by others. The nurse/patient interaction may become so transcendent, the nurse and patient experience the interaction as sacred.  

*Sacred Space*

The presence of the nurse and patient in the nurse/patient interaction may become so intimate or transcendent that this special interaction can be described as a sacred space. The word sacred comes from the Latin word sacrare, to make holy, to consecrate (Wright & Sayre-Adams, 2001). The concept of space has been examined from a philosophical perspective by Merleau-Ponty (1962), who described space as “the means whereby the positing of things becomes possible” (p. 243). Space is not only the physical environment or setting, but also the openness to thoughts, action, or “something” for consideration or study. Sacred space would be a very special, respectful place for sharing “something” between two people.

The special interaction and sharing between the nurse and patient is a unique presence of interpersonal knowledge that has been identified as sacred (O'Brien, 1999). The interaction between the nurse and patient should involve respect and reverence by both individuals. The sharing between the nurse and patient may also involve the caring, feeling, and understanding of the needs and concerns of the patient. Through sharing and connectedness, the nurse and patient may be aware of the presence between them – which is being aware of the sacred space. Something becomes sacred due to the reverence and significance an individual feels toward the item or experience (Wright & Sayre-Adams, 2001).

If something is sacred due to the beliefs and feelings an individual has toward the object or experience, then awareness is an important part of the
sacredness. According to Wright and Sayre-Adams (2001), sacred space exists because it is an area in the consciousness where an individual feels a connection with the holy or sacred. If a connection is felt, the sacred space is not made or created – an individual is just made aware of it. Sacred space is thus always around us – an individual just has to become aware of it, know it is present, and participate fully in experiencing it. Once open to sacred space, the consciousness and power of the individuals in the space engage in reverence, wholeness, and healing. It is the space between you and I, the “and” where the sacred space exists and where the you and I connect (Wright & Sayre-Adams).

Quinn (1992) described the healing environment created in caring for patients as a sacred space. Through the use of a technique called Therapeutic Touch, a specialized nursing intervention, Quinn described nurses removing barriers to the healing process and allowing a sacred space for healing to emerge. Wright and Sayer-Adams (2001) also believe the sacred space is an important place for healing and wholeness to occur.

Packard (2004) uncovered sacred space as she and eight nursing students lived the nursing instructor/ student nurses relationships across a semester of time. Jean Watson, a nurse theorist, experienced sacred space in her personal life through her freak accident and her husband’s subsequent illness. Watson (2001a) journaled these personal events and shared her innermost experiences to help describe her definition of postmodern nursing. Other nurse researchers have described the nurse/patient interaction as spiritual, using the term sacred space (see Appleton, 1994; Cooper, M., 1988; O’Brien, 1999, 2001, 2003; Sarter, 1987; Watson, 2001b).
Sacred space, presence, caring, art, and science – all elements of nursing – can intertwine in various ways to create the experiences of being in nursing.

**Being**

An important concept in this study is being or to be. Being was defined and described by Heidegger (1927/1962). Originally written in German, and translated and interpreted many times, Heidegger’s book *Being and Time* is a description of a philosophy of being, or what he called “Dasein.” In one of the translations of Heidegger’s work, Gelven (1970) stated that Dasein is a process or activity of existing, not what it is that exists. *Being* and *to be* are used interchangeably, and either concept is indefinable; that is, *being* is not an entity to be defined. The only way to understand *being* is to discover the meaning of Dasein. The meaning of *being* is “what is to be found out by the asking” and can only be discovered from asking about how it was *to be* from a “relatedness backward” (Heidegger, 1962/1999, p. 277). This “relatedness backward” is the way to understand being – an object is not being studied, but *looking back at a process* is being studied. In other words, the best way to define *being* is to look at a situation after it has occurred and focus on the process that occurred. I may not necessarily understand a nurse/patient interaction until I look backward at what occurred during my interaction with a patient. I believe nurses can potentially experience *being*, or Dasein, in every nurse/patient interaction.

An example of *being* occurred when I was the nursing instructor with four nursing students providing care for a 529 pound patient who had fractured his hip. The nursing students were assisting the patient so he could use a bedpan. Through
observing the students, I could tell that each student was impacted by this interaction with the patient. The object being studied – looking at the students – told me the students were affected by their interaction with this patient. I could only understand the being – the experience of looking back at the process – by listening to the meaning the students expressed about their experience of this interaction.

As a nurse, my experience of being was intertwining the science of nursing – assessing his skin for breakdown as we turned him, objectively looking at his skin color, watching his breathing, as well as the art of nursing – talking to him about how was he feeling, did he have any family coming to visit today, wasn’t this a beautiful fall day. This is an example of a nurse intertwining the art and science of nursing as being in a nurse/patient interaction. In comparison, the students’ experiences of the nurse/patient interaction were overwhelmingly focused on the smells they experienced in the room. The smells were the being in the interaction for each of the four students. To relate being to nursing, a nurse must know how it is to be in a nurse/patient interaction – to experience the intertwining of the art and science in nursing practice (Benner, 1994).

In describing being, an individual is reliving the process of an experience – what it was like to be in the experience. As an individual reflects back upon being, the individual becomes aware of the meaning. Meaning is how an individual interprets an experience of being. For example, in the above experience with the obese patient, I described what it was like to be in the experience. After reflecting back on the experience, I realized that I experienced a completely different being
than my student nurses. Therefore, the meaning of that experience for me was how I responded as an instructor and expert nurse differently than my students in the same interaction. Meaning is what feelings, thoughts, and perceptions an individual has in an experience. Meaning is the organization of what happens to an individual; it is to make sense of what happens (Benner & Wrubel, 1989). Meaning is an interpretation of an experience, and meaning of the same experience will likely be interpreted differently for each person.

Eisner (1998) discusses the concept of being from a reflection back upon an educational entity that Eisner named educational connoisseurship. The “ability to make fine-grained discriminations among complex and subtle qualities” is how Eisner defines educational connoisseurship (p. 63). The connoisseurship of nursing is to appreciate the realm of nursing as an art – as Eisner states “the character, import, or value of objects, situations, and performances” (p. 63). Eisner suggests that as someone becomes a connoisseur of an entity, an expansion of the awareness of the subtleties in the qualities of the entity occurs. In valuing the art of nursing, I become a connoisseur of the differentiations as students discover and begin to live experiences of the art of nursing.

Eisner (1998) identified the theory-practice relationship in any art form. Eisner stated that labels and theories provide a way of seeing but also a way of not seeing. By this statement, Eisner is suggesting that one must move beyond cognitive knowledge, to disregard what one knows. If an individual focuses on what is seen, or known, perception is limited to what can be labeled or fit into a theory or concept. Moving to what cannot be labeled, seen, is moving beyond what
is known. The ability to move beyond what is known is to move from doing to being. Eisner defines the processes of connoisseurship as examples of epistemic seeing. Epistemic seeing was first coined by Dretske (1969) and was defined as knowledge obtained through sight. Eisner argues that epistemic seeing is defined through more than sight – that all senses are involved to determine awareness of the qualities of the object/process being discovered.

Research in Nursing

To understand the art and science of nursing, the research methodology to discover knowledge and meaning of nursing becomes important. Research in nursing has two methodologies for determining answers to questions – quantitative research and qualitative research. Philosophically, a research question asks how do nurse researchers know what is true? The philosophical framework to know what is true in nursing was historically the science of nursing, or quantitative research. Nursing looked at objective, raw data – how a person was as an individual with traits or variables. These traits or variables - for example, pain, anxiety, or caring - were viewed as “context-free elements to be combined according to formal laws that can be discovered through scientific method, the goal of which is prediction and control” (Leonard, 1999, p. 316). This view is known as the Cartesian view of understanding the person, who is always seen as an object, or subject in the world of research.

In the situation of the 529 pound patient described above, I studied the student nurses as they interacted with a patient. I observed the students turning a patient, using skills to clean him after he used a bedpan, and facial expressions of
the students. I studied the students objectively as subjects, looking for traits or variables as they interacted with the patient. I could have measured the student nurses’ anxiety or caring by using a tool with measures that correspond to numbers to analyze their anxiety or caring for the patient. This description of research is scientific or quantitative research, and was the framework for building the body of nursing knowledge. Traditional science is still of value in nursing, particularly in studies that measure science – for example, measuring the levels of arterial oxygenation to timing of extubation by the ICU nurse in post open heart surgery patients.

In contrast, the philosophical framework to understand what is true in nursing can also be answered by studying from a qualitative research perspective. Qualitative research incorporates many methodologies that search for the meaning of a phenomenon of concern. Meaning is difficult to study by using objective, scientific methods. Meaning is understood through qualitative research, or from a phenomenological viewpoint. Phenomenology is a philosophy that focuses on “what does it mean to be a person?” Being, described by Heidegger (1927/1962), is the center of the Heideggerian phenomenological perspective of nursing research. As a nurse researcher, I return to the situation of the student nurses interacting with the 529 pound patient. In understanding the meaning experienced by the students in this nurse/patient interaction, I would ask the students to describe the thoughts, feelings, and experiences in this interaction. I am learning the meaning of student nurses from their being-in-the-world as student nurses interacting with a patient – in this example, totally overwhelmed by the smells in caring for this patient.
The data collection and analysis of nursing research is completely different in the scientific, quantitative focus than the phenomenological, qualitative focus. The science of nursing is best understood from a quantitative, measurable scientific focus of research. The meaning of the art of nursing – the concepts of caring, presence, and sacred space - would best be understood from phenomenological nursing research. Therefore, the intertwining of the art and science of nursing – the being of nursing – is best understood from the phenomenological approach.

Pedagogy of Nursing Education

The traditional nursing curriculum is based on a conceptual or theoretical framework of nursing. Conceptual frameworks organize nursing education around concepts, facts, propositions, postulates, phenomena, theories, and variables of a specified model or theory of nursing (McEwen & Brown, 2002). Bevis (1989) identified that virtually all nursing curricula are based on a model that includes a philosophy of nursing; a conceptual framework; behaviorally defined, measurable objectives; learning activities; and measurable criteria for evaluation. Curriculum is “the interactions and transactions that occur between and among students and teachers with the intent that learning occur” (Bevis & Watson, 1989, p. 5). Nursing curricula must meet standards set by accrediting bodies of nursing education – the State Boards of Nursing, and either the National League of Nursing (NLN) or the American Association of Colleges of Nursing (AACN). Every school must meet state standards, and every school must be accredited by either the NLN or the AACN (McEwen & Brown, 2002). Every school of nursing focuses on the content and process of nursing – using content (e.g., diseases, medications, nursing
interventions) and process (e.g., critical thinking, reflective thinking, problem solving) to achieve the outcomes of completing the curriculum.

The content taught in a nursing curriculum must meet the requirements of the accrediting bodies. Traditionally, nursing curricula have been taught from a scientific methodology of education, the Tyler method of behavioral objectives and linear outcomes. Tyler (1949) created a model in education for writing behavioral objectives that identified specific outcomes to be achieved in a learning environment. A behavioral learning theorist, Tyler believed that learning occurred when the teacher identifies behavioral change in the learner and learning is demonstrated by this permanent change in behavior. The Tyler behavioral objective model of learning has framed nursing curricula for many years (Boland & Finke, 2005).

Bevis and Watson (1989) first questioned the use of the Tyler curriculum model, identifying that behavioral objectives represent minimal achievement levels. The Tyler curriculum model subscribed to the fact that all learning can be measured by behavioral change – for example, how to turn a 500-plus pound patient successfully. This manner of learning does not allow for interpretation from multiple realities or intuitive, constructed knowledge – or the personal feelings of the learner concerning how to cope with the odors of an obese patient. While useful for skill training and instruction, behavioral objectives leave no room for creativity, individualism in thinking or experiencing nursing, and are too rigid and restrictive. Moccia (1988) stated in nursing education there should be no list of what to teach because education is “not about content, but it is about soul, it is about process” (p.
iv). The example of caring for the obese patient is an example of learning from process.

Nursing faculty teach and revise content in nursing education through revision of behavioral objectives, and have organized curricula of nursing education in this manner for over 40 years. Ironside (2004) believes the focus in nursing education should move beyond the content to focus on the process of nursing education. The focus on content follows the behavioral learning theory. As nursing educators have become researchers into the process of learning, the focus shifted from content of nursing knowledge to process of how to think and practice in nursing. Through this shift, theories of learning and cognitive development have been implemented into nursing education. Research on baccalaureate nursing education has traditionally focused on the curricular and pedagogical methods used in institutions of higher education. The focus of this traditional research is outcomes-based, competency-based education as related to various curricular and pedagogical methods.

The pedagogical terms frequently identified in traditional nursing research are critical thinking and problem-based learning. Only in these past 10 years has the focus of nursing research changed from the faculty’s educational perspective to the students’ experiences. The research with student nurses has focused on the development of student competence in the clinical setting, on learning situations with experienced nurses as preceptors in the clinical setting, and on how to learn to critically think. The students’ voices have provided a rich knowledge to the literature of nursing education.
Student Nurse Learning

Diekelmann (1993, 2001) is an innovative nurse researcher who used interpretative phenomenology to hermeneutically analyze the lived experiences of nursing students, teachers, and clinicians over 12 years and to name a new nursing pedagogy. Narrative Pedagogy is an interpretive alternative pedagogy that focuses on “presenting multiple epistemologies, exploring ways of knowing and practices of thinking, and interpreting as central to understanding the nature of experiences” (p. 54) in nursing education (Diekelmann, 2001). Deikelmann states conventional pedagogy includes outcomes, competencies, problem-based learning, and critical thinking framework. Narrative Pedagogy, an alternative pedagogy, critiques, examines, explores, and deconstructs experiences of students, teachers, and clinicians to experience learning in nursing.

Diekelmann’s (2001) research in Narrative Pedagogy focuses on the differences in “knowing” nursing content and “doing,” or applying the content in caring for patients. Diekelmann contends that traditional behavioral pedagogy emphasizes learning content and not “thinking,” or application of knowledge in nursing care to patients. Diekelmann reported her research using Heideggerian phenomenology to uncover the experiences of practice of students in baccalaureate nursing education. Her results uncovered themes in “applying content as thinking” and “learning as cognitive gain” (2001, p. 245).

Critical thinking is a concept addressed in research in nursing education. Many nurse faculty members devote research to the concept of critical thinking (see Facione, N., Facione, R., & Sanchez, C., 1994; Haffer & Raingruber, 1998; Loving
Wilson, 2000; Smith & Johnston, 2002;) and realize the importance of
developing critical thinking in nursing students. Critical thinking is defined by
Raingruber and Haffer (2001) as

a multifaceted process that includes logical, rhetorical, and humanistic skills
and attitudes that promote the ability to determine what one should believe
and do. Critical thinking requires one to actively process and evaluate
information, to validate existing knowledge, and to create new knowledge.
(p. 3)

Critical thinking is so important that Raingruber and Haffer (2001) and
Alafaro-Lefevre (1995) have written entire books for nursing students devoted to
helping the students learn critical thinking.

Reflective practice is a concept that is part of critical thinking. Dewey
(1933) stated reflective thinking is turning a subject over in the mind and giving it
serious and consecutive consideration. Schoen (1983) defined the reflective
practitioner in a book describing how professionals think in action, either while in
the moment of the situation, or at a time of reflection after the situation. Brown and
Gillis (1999) summarize an extensive literature review on the topic of reflective
thinking, and summarize by saying “reflection is needed daily by practitioners to
unite theory and practice” (p. 171). Reflective thinking in nursing education is
assisting the student nurse to begin to question and process experiences in the mind,
and to develop personal professional philosophies. An aspect of reflective thinking
is journaling.

Journal writing is identified as one method for making meaning of a clinical
experience (Callister, 1993). The clinical learning journal was described as a
written record that reflects the student nurses’ attitudes, feelings, and expansion of
his or her cognitive learning. Journal writing allowed the active and integrated learning between theory, research, and clinical experiences to come alive for the student nurses. In this study, journal writing is one kind of reflective writing. The word reflection was defined by Taylor (2004) as a means of “throwing back thoughts and memories, in cognitive acts such as thinking, contemplation, meditation, and any other form of attentive consideration, in order to makes sense of them” (p. 28). Reflective thought involves experiencing (i.e., being), interpreting (i.e., meaning), and therefore learning from an interaction.

Nursing students have identified through reflective thinking the concepts of fear and anxiety. In a study by Neil-Urban (1994), senior nursing students identified fear and anxiety in their initial days of patient care; however, this study focused on the concept of caring and did not discusses fear or anxiety as a theme of these participants’ experiences. A study by Bradby (1990) described the lived experiences of nursing students in England. The methodology included interviews, diary keeping, and psychometric testing of the participants. Results focused on how student nurses learned essential elements of patient care. The words fear and anxiety were used in the description of feelings as students learned in their education.

Several articles discussed anxiety in nursing students in the clinical setting. Kleehammer, Hart, and Keck (1990) found three causes of student anxiety in the clinical setting – fear of making mistakes, fear of the initial clinical experience on a unit, and performing clinical procedures. These fears were named by the students in the above study. Audet (1995) discovered an inverse relationship between
student nurse anxiety and learning – as anxiety increases, learning decreases in the clinical setting.

Cognitive learning theories are frameworks to explain how people learn by responding to whole situations. Cognitive theorists who provide framework for nursing education include: Perry (1970); Kegan (1982); Kolb (1984); Belenky, Clinchy, Goldberger, & Tarule (1986); Baxter Magolda (1992); and King & Kitchener (1994). Each theorist will be discussed briefly, including application of important concepts to nursing education.

William Perry (1970) was an early cognitive researcher in how students interpret and make meaning of the teaching and learning process. Perry postulated stages, or “positions” of intellectual and ethical development. Students move through nine positions, yet these positions can be recategorized into four positions – dualism, multiplicity, relativism, and commitment to relativism. Perry’s theory was developed with male students in the 1960s at Harvard University, and entered college at the multiplicity level, graduating at the relativism level. With the diversity of students in colleges today, and the differences in maturity of thinking, today’s students perform at lesser levels in Perry’s positions (Love & Guthrie, 1999).

Robert Kegan (1982) described in his theory “Orders of Consciousness” that making meaning of reality is done through three activities – physical (grasping or seeing), social (always requires at least one other person), and survival (in doing it, we live). Kegan describes six levels of sense making that occur across a person’s entire life span, and he perceives the college years as a significant time of making
meaning. Nursing education and student nurses fit in Kegan’s theory because nursing is so much of the three activities involved in making meaning – physical, social, and survival. Student nurses struggle immensely with the fit of the physical, or skills of nursing (e.g., giving injections) with the social (e.g., learning to relate to a stranger, the patient). The survival could be related to what many nurses describe as a “calling.” Florence Nightingale (1859/1969), the founder of nursing, stated in the Florence Nightingale pledge “to devote myself to the welfare of those committed to my care” (p. 18).

Kolb (1984) developed a theory of learning styles. The key concept of Kolb’s theory is that knowledge is created through steps in involvement in an experience. These steps involve four learning styles - doing, watching, thinking, and feeling. While learning incorporates all four styles, each student tends to gravitate toward one as his/her predominant style of learning. For example, I have witnessed a student who just cannot perform a task unless watching someone perform a similar task first. Kolb’s theory suggests that nursing educators use varied methods of teaching and instruction. If students learn differently, then different methods of instruction are needed to reach all learners as they experience creating knowledge of nursing.

In 1986, Belenky et al. developed a “Women’s Ways of Knowing” theory, based upon Perry’s work and upon Gilligan’s (1982) theory of women’s moral and personal development. Belenky et al. identified five epistemological perspectives addressing women’s concerns of self, voice, and mind. Nursing students enter the junior year using received knowing, the third of the five epistemological
perspectives. Students listen to the nursing faculty as though the faculty know the “truth.” During the next two years, the students move into procedural knowledge and then to constructed knowledge as they make meaning of nursing.

The theory of Belenky et al. (1986) is important to nursing because it was the first cognitive developmental theory to focus on women. Of interest in the nursing literature, Eyres, Loustau, and Ersek (1992) investigated 21 student nurses to type the cognitive development of the students using the Women’s Ways of Knowing scale. The students showed meaningful differences in their cognitive development based upon age. A key point from the Eyres et al. article showed that student voices spoke about the struggle to balance their developmental challenges at the same time they were involved in the high responsibility of the lives of their patients.

Baxter Magolda (1992) conducted a longitudinal study of complex reasoning among college students and developed a cognitive development theory called the epistemological reflection model (1992). Baxter Magolda identified four patterns of qualitatively different knowing that described the levels of reasoning of college students. The four patterns are characterized by epistemic reflections, and each way of knowing leads to particular expectations of the person, peers, and instructor in learning settings. Baxter Magolda highlights how students think, and studied both men and women, which accounts for variations of thinking depending upon gender.

King and Kitchener (1994) developed a theory called the Reflective Judgment Model, which describes the development of reflective thinking. The
model developed from a question “How do people decide what they believe about vexing problems?” (p. 2). King and Kitchener believe that reflective thinking is a part of critical thinking that reasons ill-structured problems. For instance, a patient who is HIV+ is hospitalized and has not told his significant other he is HIV+. The student nurse caring for the patient knows this fact, and the student struggles with what to tell the patient about his new medication in front of the significant other. The student knows he/she should never give a new medication without informing the patient what he is getting (a new medication for his HIV); yet with the visitor present, the student nurse is not able to tell the patient about his medications without also disclosing the patient’s diagnosis. This example illustrates how reflective thinking allows theoretical knowledge to assist in practicing ill-structured problem solving.

The above described theories apply to nursing students in how they develop cognitively. In contrast, theories of learning are models for how individuals learn. They describe intellectual potential or students’ learning ability. Another distinction between theories of learning and cognitive developmental theories is that learning theory explains how learning happens; cognitive development theory describes the changes in thinking and behavior as learners make meaning across a continuum (Ignelzi, 2000, p. 5). There are several learning theories that apply to nursing students - Gagne’s Conditions of Learning (1977); Bandura’s Social-Cognitive Learning Theory (1986); and Vygotsky’s Cultural-Historical Theory of Psychological Development (1997).
Gagne (1977) identified five varieties of learning categories – verbal information, intellectual skills, cognitive strategies, motor skills, and attitudes. These categories of learning are separate and may occur interactively. For example, a junior nursing student is using verbal information from freshman chemistry class to identify compounds that constitute electrolytes in a patient’s blood and urine; learning the symbols for the electrolytes (an intellectual skill); and using cognitive strategies to apply what each electrolyte value means to the patient’s overall health state. Categories of learning are important for nursing faculty to understand in teaching in the classroom and in the clinical setting.

Albert Bandura (1986) identified the importance of modeled behavior in his theory of social-cognitive learning. Once the learner has encoded the experiences in symbolic form, and can perform the behavior, self efficacy becomes key to the theory. Self efficacy is the learner’s belief in his/her capabilities to perform the actions/abilities successfully. Bandura’s theory in many ways defines the learning, modeling, and performance of competencies of nursing technical skills – giving injections, starting IV’s, doing dressing changes, and using complex equipment for patient care in the intensive care units, emergency rooms, and surgery. Only through modeling and then repetitive practice does skill acquisition occur in nursing. No other theorist best fits this skill acquisition capability than Bandura.

Vygotsky (1926/1997) developed a cultural-historical theory of psychological development. The theory has constructivism as the key to learning and development. Learners must include the role of the culture in learning; recognize that cognitive development proceeds through qualitative transformations;
and know the importance of social interaction during learning. Nursing students have to learn the culture of nursing – the caring, reflective practice, and critical thinking needed to become a competent practitioner. Nursing students must be patient and know that learning comes over the rest of their careers – that learning will continue throughout each experience in college and in practice. Nursing students must also be aware of the peer interactions and role modeling from practicing nurses and faculty that is important to learning nursing.

In general, cognitive development theories and theories of learning are not researched nor applied in nursing pedagogy. In particular, Eyres et al. (1992) identified the lack of empirical work on cognitive development of nursing students. Because this research focuses on traditional baccalaureate nursing students, the overall outcome of nursing pedagogy incorporates both a professional education and a college degree. King and Baxter Magolda (1996) identified the hallmarks of a college-educated person as having “a broad understanding and deep appreciation of human differences” (p. 163) as well as a sense of caring and reflecting skills. According to King and Baxter Magolda, a college-educated person should demonstrate

affective attributes as an eagerness to continue to learn, an appreciation of the value of working with diverse others on problems of mutual interest, the will to take personal responsibility for one’s own views and actions, and the desire to make a positive contribution. (p. 163)

In an ideal world, a nursing student would develop these traits through the college experience in a baccalaureate nursing program.
Chapter 3
Methodology

“When I become aware of myself typing in boxes and providing recipe-like steps, I feel at odds with the flow and spirit of qualitative inquiry. I believe we simply talk, listen, observe, read, become a part of something bigger than ourselves, become a part of the ‘thing itself’, dwell with thought, and interpret, while remaining wide awake and attentive to the appearance of the phenomenon of interest.”

Patricia L. Munhall, 2000

The purpose of this study was to discover how student nurses experience being and presence in nurse/patient interactions. In this study, a qualitative method of research was the mechanism to learn how student nurses experience being and presence in nurse/patient interactions. In this chapter, I restate the research questions identified in Chapter 1 and discuss the appropriateness of using qualitative research, specifically journal writing. I discuss journal writing as a tool to discover the phenomenology of being a student nurse and the hermeneutics of the meaning of nurse/patient interactions to student nurses. The participants in this study are described and the setting for the study is discussed. Last, methodological assumptions and limitations, as well as analysis of the study are discussed.

Approach and Rationale

The research questions for the study were:

1. What is the meaning student nurses make of their experiences in nurse/patient interactions?
2. How do student nurses experience the various levels of presence in their nurse/patient interactions?

3. How do student nurses describe being in their nurse/patient interaction?

The purpose of the study was to understand how student nurses experience being and presence in nurse/patient interactions. The research questions, along with the purpose of the study, dictated the use of a qualitative method of research due to the need to understand and interpret nurse/patient interactions from the student nurses’ viewpoints. Denzin and Lincoln (2000) stated qualitative research locates the observer (researcher) in the world of the participants, using an interpretive, naturalistic approach. Boyd (2000) identified qualitative research as “involving broadly stated questions about human experiences and realities, studied through sustained contact with persons in their natural environments, and producing rich, descriptive data that help us to understand those persons’ experiences” (pp. 69-70).

The importance of understanding how student nurses make meaning of their experiences of being was illustrated in a nurse/patient interaction of one of my student nurses. As the experienced nursing instructor, I assigned the student nurse to care for a young female patient with kidney failure who was receiving dialysis. The day before, the classroom presentation topic had been about nursing care of a patient in kidney failure. I spent the clinical day interacting with the student and patient and believed we had a great day of learning – the real world and classroom came together, which is usually a great learning experience! The student told me at the end of the day she had not been able to learn much of anything. This student’s experience was that the clinical environment was
extremely stressful – she saw so much “going on” with this patient. The student related that due to her stress, she did not know how to focus nursing care for this patient and felt the clinical experience did not allow her to learn. The student’s main concern was that the patient and she were the same age, and she expressed she just could not get beyond how much she identified with the patient.

The above student/instructor example illustrates verstehen, which means understanding, or the “process by which we make sense of or interpret our everyday world” (Schwandt, 2000, p. 121). Verstehen places emphasis on the human capacity to know and understand others through empathetic introspection and reflection based on interactions with people (Boyd, 2001). The student nurse in the above example interpreted the experience with the renal patient differently than I. If I had understood how the student was feeling or interpreting the specific nurse/patient interaction, I would have made changes in the clinical experience for the student. I could not tell the meaning the student made from her experience of this patient interaction – I could only understand from talking to the student. Observation does not necessarily allow the phenomenon to be understood – talking to and hearing the meaning is how a phenomenon is understood.

In this study, I wanted to understand how student nurses interpret, or make meaning of experiences of being and presence in their nurse/patient interactions. The contextualizing of a situation differs among people based upon the meaning and understanding of the situation. One means for fully discovering meaning is hermeneutic phenomenology. Hermeneutic phenomenology, or hermeneutics, is a method of studying “how people interpret their lives and make meaning of what they experience” (Cohen, Kahn, & Steeves, 2000, p. 5). Hermeneutics is
holistically studying the person in the situation where one wants to understand meaning. The word hermeneutics comes from the Greek verb hermeneuo, meaning to interpret. Although many approaches to qualitative research exist, hermeneutic phenomenology provides one of the most powerful approaches to understanding the experiences researchers hope to understand.

Crist and Tanner (2003) stated hermeneutic phenomenology should be used as a research methodology “when the research question asks for meaning of a phenomenon with the purpose of understanding the human experience” (p. 202). In seeking to understand how student nurses experience being and presence in their nurse/patient interactions, I wanted to understand the emic perspective, or the view from inside a student’s perspective. Schwandt (2000) discussed hermeneutic phenomenology as a comparison between things of the world and social reality. Things of the world, such as particles, molecules, or atoms, have no meaning as beings in relationship to the world. Human beings, in contrast, have social interactions from which they construct a social reality. Hermeneutic phenomenology is the appropriate research methodology for this study of student nurse/patient interactions.

Observing student nurses in nurse/patient interactions is important to a nurse educator who is evaluating how student nurses are performing the skills of nursing. These observations are a means of measuring the behaviors of student nurses. The meaning the students have that motivate, drive, or cause the behaviors is the interpretation that was important in this study. Munhall (1994) made a distinction between research that looks at behavior versus research that looks at the meaning of the behavior. Much of the focus of nursing research on
student nurse learning has been on the behaviors (e.g., skill, content, and critical thinking) of nursing students. The importance of this study was that the meaning of behaviors in nurse/patient interactions were explored, not the behaviors themselves. Since the literature is void of research on the meaning of nurse/patient interactions to nursing students, this study was important in understanding the meaning behind the behaviors of student nurses in authentic nurse/patient interactions.

An example of focusing on meaning and not behaviors would be in the description of caring for the 20 year old patient with renal failure discussed previously. The student nurse and I both experienced nurse/patient interactions with this patient. Our contextualization of this situation, however, was very different. As the instructor, I believed the experience connected the classroom learning of renal failure to seeing a patient with renal failure in the clinical setting. My behavior was the active provision of the care this patient needed for the day. In contrast, the meaning the student nurse interpreted from the experiences was completely different. The student stated it was difficult to focus because the 20 year old patient had “too much [that] was going on,” and because she identified too closely with the patient. The student nurse’s behaviors were avoidance and not active performance of the nursing care; she passively watched me perform the care. If the student told me what “too much going on” with the patient meant to her, and if she had described her thoughts and feelings related to what she felt about the age similarity, I could have learned her experiences of being and presence in this nurse/patient interaction. This paragraph is an example of using
hermeneutics to understand being and presence of student nurses in nurse/patient interactions.

Understanding how student nurses experience being and presence, and the meaning they make in nurse/patient interactions, will allow nurse educators to identify how to improve learning from a constructivist nursing pedagogy. Constructivism is an active, socio-culturally constructed learning, where knowledge and truth are created, not discovered by the mind (Schwandt, 2000). In contrast, nursing education has traditionally been a behavioral outcome-focused educational process. By using constructivist pedagogy, nurse educators allow students to construct their learning in the socio-cultural world of nurse/patient interactions. In the previous example, the student nurse was not interacting with her patient because of close identification with the patent. If I were using the behavioral education perspective, I would believe the student nurse was minimally meeting course objectives. Applying the constructivist perspective, I know the meaning behind the student’s inaction, which changes my interpretation of her learning outcome.

Nursing educators who use the framework of constructivist pedagogy would not just observe behaviors of student nurses in the clinical setting to identify clinical learning. The student would be the active creator of his/her experience in caring for a patient. The understanding of being experienced by the student nurse in a nurse/patient interaction would create learning in constructivist nursing pedagogy. For example, the student caring for the patient with kidney disease may not have experienced a chronically ill 20-year old. The student nurse would then construct a new meaning of health and illness in a 20-year old.
contrast, using behavioral scientific pedagogy, a nursing instructor would have passively shared chronic illness facts in a classroom or in assigned reading. The student nurse constructed the new knowledge of health and illness through her active learning in the clinical setting. The role of the nursing instructor in this example was to be open to the thoughts and sharing of the student nurse, to validate and encourage active construction of knowledge. The interpretation of the \textit{being} in the nurse/patient interaction is the key to constructivist learning.

\textit{Participants and Setting}

The participants in this research were undergraduate nursing students at a midwestern, Research I institution. These students were sophomores in college and enrolled in their second nursing course involving clinical experiences with patients. The institution was chosen by the researcher for several reasons. First, the institution has a traditional college campus, not just a school of nursing. The importance of choosing a traditional college campus was that students take both nursing courses and non-nursing courses across a four-year curriculum. This curricular design allows balance in the student nurses’ lives between nursing courses and non-nursing courses. The curricular design was important for a more integrated learning experience as college students – learning nursing as well as having opportunities for a traditional college experience, including interactions with non-nursing students.

Another rationale for the choice of setting is the reputation of the university. This university was known for the diversity of its student body, which enabled creation of a more diverse group of participants. Because participation in the study was by a self-selected sample of convenience, I was not able to control
for diversity in the participants. Another rationale for the choice of setting was that each student was well versed in the use of computers and electronic mail. A requirement of the institution’s nursing curricula is that the clinical paperwork is electronically mailed (emailed) by each student to the instructor. An important part of the data collection of this study was the expertise in use of electronic mail.

The student nurses were enrolled in a course entitled Fundamentals in Nursing. The Fundamentals in Nursing course was an entry-level course to nursing, the objectives which were to learn basic nursing skills – bedmaking, taking vital signs, basic nursing terminology, and interacting with patients. The student nurses in this Fundamentals course had opportunities four hours every other week to experience interviews/interactions with patients in a clinical setting. The students could be nurses in nurse/patient interactions in this course without the stressors of doing – for example, giving injections or starting IVs. This course design was important as student nurses first experience nurse/patient interactions in an authentic nursing setting, not in a communications laboratory setting as described in some schools of nursing in the literature review.

The sophomore nursing class of the selected institution was 117 students, divided into two sections of the Fundamentals course. The entire class was invited to participate in this study. The student nurses chose to participate in the study after two group meetings with me; therefore, student choice to participate was the reason for inclusion. The students were told that their participation would not affect their coursework in the nursing program.

In the initial meeting, an explanation of the research was given to the entire group at the end of a regularly scheduled Fundamentals class period. The
initial contact with students allowed them to become acquainted with me and the study. A focus of the initial meeting was to explain to the students the sharing they would do by journaling. The time required for the students to relate experiences in nurse/patient interactions was discussed. Another priority of this meeting was to assist the students to understand the intimacy of the thoughts and feelings they would be sharing through self reflection by journaling. The students were told how their thoughts and feelings would be respected and protected. The students were also told their reflections would remain confidential and coded so they would not be identified by their words. I also asked the student nurses what they would like to learn from their involvement in my study. From the student viewpoint, involvement in this study could have had another outcome I did not consider. I was open to any student input, true to constructivist pedagogy. I also told the students that the results would be shared with them at the end of the study.

The consent for participation in the study was explained, and the students were allowed to take the consent home and think about participation. My pager number and email address were given to the students, who were invited to ask questions about the research. I attended the next scheduled class to answer any questions and to obtain the informed consents. The students were told they had the right to stop participation in the study at any time, as well as students who did not initially begin the study had the right to start participating at any time. The students were involved in data collection until the end of the semester.

Once consent was obtained, each participant was to complete a questionnaire to provide background information (see Appendix A). The
questionnaire was important because constructivist theorists believe learning occurs by building upon past experiences. I wanted to learn if the students had worked with patients in the past; if the student or a family member of the student had significant experiences in nurse/patient relationships; and if any nurse/patient interaction in the previous semester had been an important experience for the student. Any past experience in nurse/patient interactions is likely to provide a building block for future experiences.

Good data collection in qualitative research depends upon the trust and openness of the participant with the researcher, called developing rapport. Glesne (1999) defined rapport as the “distance-reducing, anxiety-quieting, trust-building mechanism” (p. 96) in getting to know the participants. A limitation of this study was the lack of time to develop true rapport with the students. Since I was not present in the clinical setting when the experiences occurred, nor part of any classroom experiences, in-depth relationships were not established. I was available multiple times across the semester at the end of the Fundamentals class to greet and to encourage the students in general in their coursework. My lack of daily presence in the students’ lives may have been a strength, as some students perhaps felt safer relating intimate thoughts and feelings to someone who was not from their school of nursing, someone who was non-threatening to their person. Student willingness to engage in and remain in the study was a concern due to limited opportunity to establish rapport between researcher and participants. Of particular concern was how to motivate the student nurses to be participants in this study. One way to motivate the student nurses was to begin by telling my story. I wanted the students to know I was once in their shoes and now wanted to
understand the student experiences in nurse/patient interactions from my role as a nursing instructor/faculty member. I also wanted the students to understand their participation would assist faculty in schools of nursing to redesign curricula to include student nurse being and presence in nurse/patient interactions.

My story took place many years ago and owns my place in this study. I was 19 years old, and a sophomore on a traditional college campus in my first clinical nursing experiences. My clinical instructor was an experienced nurse educator who always seemed perfect to me with her crisply starched white uniform and cap, military erect posture, and unbelievable organization. I was new to clinical experiences, and scared to death of my instructor! She was not warm and approachable; just asking her a question frightened me. She assigned me one day to a female patient who had just had a mastectomy a few days earlier. The woman’s surgeon came to her room to see her that morning. My instructor insisted I go in the room and observe the interaction between physician and patient. The surgeon took the dressing off the wound, took out the stitches, and without giving the patient any pain medication, proceeded to express large clots from the wound. I became very sick to my stomach and had to sit down, as I almost fainted. My instructor came into the room to check on me and immediately left the room. The nurse caring for the patient was more supportive of me in this experience than my instructor.

At the time, all I could feel was mortification – I was supposed to be a nurse, and I couldn’t even watch a procedure! Upon reflecting on the experience, I realized the biggest part of my reaction was due to my mother’s mastectomy a few months earlier. I had so much emotion from her experience, and I was new to
the clinical setting with this instructor; therefore, my meaning of this nurse/patient interaction was unique. Due to my background with my mother, and due to my fears and unease with my instructor, I had a very different reaction in this nurse/patient interaction than another student nurse might have had in a similar nurse/patient interaction. The objective experience was simply a new nursing student watching a surgeon treat a patient who had a mastectomy. The meaning I experienced from this nurse/patient interaction was totally different than the mere objective perspective. This nurse/patient interaction affected me immensely, and I vowed if I was ever an instructor, I would truly be caring and concerned for my students. Owning my experience was an important piece to my bias in this study.

I was hopeful the initial two meetings with the students conveyed to them that (a) I sincerely respect the words they shared with me and (b) their participation in this study was significant both to their personal growth and to nursing education in general. The students may or may not have been influenced by my sincerity – I cannot control for their responses to me personally. My belief was that the students perceived I was genuine in my devotion to bring their words to light. My occasional presence to visit the students was also a reminder of my sincerity – I took chocolate candy and was always upbeat and supportive of the students when I visited. I believed another avenue to encourage motivation was to understand the significance of their involvement in this study. By participating in this study, these students provided the first voices of student nurses’ experiences of being and presence in nurse/patient interactions, and may inspire future student nurses. The student nurses in this study were sharing their stories – also the methodology of the popular “Chicken Soup for the ______ Soul” books
by Jack Canfield and Mark Victor Hansen. Perhaps to point to the similarity of the stories of life experiences shared by people in these books to the students’ experiences with patients was helpful. The comparison may have allowed the students to believe the importance of sharing their stories by participating in this study.

**Data Collection**

The data necessary to learn about the student nurses’ experiences of *being* and presence in nurse/patient interactions resulted from reflection. The manner of recording these reflections was through journaling. The students recorded the thoughts, feelings, and emotions of *being* and presence experienced in their interactions with patients. Journal writing was the way of recording the reflections of the lived experiences of the student nurses during the data collection period. Taking time to put words to the thoughts, feelings, emotions, or just retelling the experience allowed for reflection and the recording of the meaning of the experiences, and perhaps discovery of something not originally seen or felt. The participants recorded the reflections by either sending the reflections by electronic mail, voice recording the reflections on a tape recorder, or writing the reflections on paper. The choice of vehicle to record the journal was to allow the student to share the thoughts, feelings, and emotions of *being* and presence in a manner most comfortable for the student.

Cohen, Zahn, and Steeves (2000) stated that a “driving force of human consciousness is to make sense of experience” (p. 59). The authors said,

The understanding people have of their world and life situation and the meaning they have made of this is usually contained in the narratives or stories they tell, first to themselves to make sense of their own experience;
then to family, friends, and other social actors in their lives; and finally to any social scientists who come asking. (pp. 58-59)

All the students chose to journal their experiences and sent these journals through electronic mail. As a researcher, I was concerned about any ethical or personal issues that may arise from journal writing. If a student became upset or needed to talk, I encouraged him or her to please call a designated course coordinator at the institution.

The meaning of the nurse/patient interactions emerged as each student experience unfolded. Due to the design of this study, the researcher was not present during the clinical experiences. The rationale for the researcher’s absence from the clinical experiences was because the students needed to be able to focus on their learning for their clinical course. The journal writing allowed for private reflections on these experiences at a later time. Through journal writing, the student nurses had a separate time to privately reflect on their experiences and to record the experiences. Set questions guided the journaling activity.

The procedure for data collection was that the students electronically journaled the clinical experiences in nurse/patient interactions after any four-hour clinical day within the 24 hour period after clinical. The time frame allowed for reflection while the experiences were still recent enough for accurate retelling. The students chose to journal after self-selected clinical experiences. The electronic journals were emailed to me. In the initial meeting, students were also given the choice to audiotape reflections or to use paper and pencil journaling. The only option chosen by the students was ejournaling. The student nurses journaled clinical experiences they chose to share across the entire time frame of the data collection period. Ideally, data would have been collected across the
semester; however, students picked and chose experiences to share based on individual choice and time availability.

The proposal for this study was submitted to the Institutional Review Boards/Human Subjects of three universities – the institution from which I obtained my doctorate; the institution where I am employed as a faculty member; and the institution where the participants attended the School of Nursing. While awaiting IRB approval from the three institutions, I met with the faculty of the School of Nursing to explain the study. One of the institutions requested a name be added to the top of the consent for contact purposes. Because this changed the consent, it was also resubmitted at the institution the participants attended. The institution where I obtained my degree did not request another submission of the consent. I met with the sophomore class, explaining the study and asking for participants. After receiving informed consent, I instructed the students in the design of the study and had the student nurses begin journaling the experiences in nurse/patient interactions.

The students were instructed to journal their clinical experiences by answering several questions. The journal questions were:

1. Describe an interaction you had with a patient today.
2. What were your thoughts or emotions while you were in the interaction?
3. Describe how you felt about yourself during the interaction.
4. Describe how you felt about the patient during the interaction.
5. What did I not ask you that you would like to tell me?
6. Any other thoughts or feelings you want to share?
These journal questions were intended to be probing yet open ended enough to elicit student reflections from the day’s nurse/patient interactions. These questions were developed based upon similar questions my current clinical students answer after clinical experiences with me. The participants had a course requirement to respond to questions about their clinical experiences. When I reviewed the reflections of my students, and looked at the questions from the lens of this study, I changed the questions. These students frequently referred to nurse/patient interactions from the passive viewpoint of watching an experienced nurse interact with a patient. Since I wanted the student reflections to be from the viewpoint of the student as the nurse interacting with the patient, question one was worded as “Describe an interaction you had with a patient today.” Since the students I work with in my faculty role frequently reflect upon the patient, question four was added, “Describe how you felt about the patient during the interaction.”

Data Analysis

In hermeneutic phenomenological research, the data are analyzed by an interpretive process. Data collection and analysis occur simultaneously, with the bulk of the analysis occurring toward the end of data collection. Hermeneutics is a circular process to uncover and identify people’s meaning and experiences. In this study, I was open to learning the meaning student nurses experience in nurse/patient interactions.

Each student who agreed to participate in this study was assigned a number. The students were to submit journal entries by choosing a number, but only one student chose a number. Therefore, I numbered the submissions as they
arrived. Because electronic mail messages have names attached, the names were cut off the paper when printed and code numbers were written on the papers. Journals were stored in individual file folders by code number and all submitted data was stored in a locked cabinet in my home.

Analysis was true to hermeneutic phenomenology. The first read through of a journal was to understand the student’s experience as a whole. The second read through began analysis of parts of the text. Cohen et al.(2000), and Schwandt (2000) discussed the hermeneutic circle, a process of data analysis in alternating attention between detail or small parts of the data, and the larger units of the data. The hermeneutic circle extended as data collection continued. The individual journals were interpreted with the meanings of the smallest units of data in relationship to the growing body of larger units of data.

Throughout interpretation of the data, the first step was to read the journal entry as a whole experience. The second step was to reread the entry again, beginning to analyze parts of the text. I made three copies of each entry and placed the copies together in each student folder. The first copy remained whole, the second copy was used to write my comments and initial interpretations, the third copy was cut and placed in folders containing exemplars. Exemplars are “salient excerpts that characterize specific common themes or meanings across informants. They are parts of stories that have similar meanings within informants’ stories.” (Crist & Tanner, 2003, p. 204). Cohen et al. (2000) defined exemplars as “bits of textural data in the language of the informant that capture essential meanings of themes” (p. 80). In my student example above, the focus on patient discomfort and the students’ meaning in ability or inability to ease the
discomfort would be an example of an exemplar. As data analysis continued, exemplars emerged from the data, and subthemes emerged.

Data collection occurred across the semester, or until saturation of data occurred, resulting in no new themes or exemplars. Benner (1994) identified that when interpretations are visible and clear, and no new exemplars or meanings emerge from narratives, then data collection is complete. Data analysis is presented in Chapter 4 of this study, and the findings, conclusions, implications, and recommendations are included in Chapter 5. The analysis was reported by themes and subthemes, and described using exemplars and quotations.
Chapter Four

Results

I feel that nursing is both an art and a science. To be a successful RN, one must utilize their scientific mind, technological and clinical know-how, one’s heart for care, and skills to heal. Patient care is a demanding and difficult career where often, you are on your feet for hours at a stretch. And you still have to smile! My ability to learn from this experience and others will separate a good nurse from an average nurse. As a hard-worker, I plan on putting many hours of practice into the work that has cared for me in the past. I hope to be a great nurse one day that can make the difference between life and death in many a situation.

Study participant, 2004

In this chapter the participants are described, including demographic details such as age, gender, and past experiences in nursing. A brief summary of the data collection period is described, and the procedure for data analysis is reviewed. The resulting themes of the data analysis are identified and illustrated by exemplars of the participants’ lived experiences.

Participants and Data Collection

The participants in this study were sophomore nursing students at a midwestern university who were in the first semester of nursing clinical experiences. I first met the 117 nursing students in January, 2004, after the study received appropriate approvals. At the initial meeting, I explained the study consents for participation, the data collection procedures, the time requirements for participation, and what would be required of them to participate in the study. The students were told they were free to choose any clinical experiences to
The six questions to be answered in the data collection period were discussed, including how the questions related to thoughts and feelings of the students as they interacted with patients across the semester. I instructed the students how to submit journal entries through a specially-created email account. After the initial meeting, and upon reflecting upon the informed consents, 48 students signed consents to participate in the study.

Once consents were signed, participants were free to participate in the study. I returned to the university every two to three weeks, where I interacted with the students in the hallway between classes or in the skills laboratory setting where they practiced nursing skills. These visits were designed to allow for personal interactions with the participants in order to stimulate study participation. Because the participants and I did not know one another, these occasional visits were intended to establish rapport with the participants. These visits always resulted in the submission of at least one email journal entry. Although email journals were received with names attached, the name was immediately removed upon the receipt of any journal entry. Therefore, I did not know if a student in the hallway or skills lab was or was not a participant in the study. Many times when interacting with a student, I would wonder if he/she was a study participant.

The summary of the process of participation in this study follows. One hundred seventeen students in the sophomore class were contacted to participate. Forty eight of these students signed consents to participate in the study. Across the data collection period, 28 of the 48 potential participants submitted journal
The 28 participants submitted 37 different journal entries describing nurse/patient interactions. These 37 nurse/patient interactions represent the data analyzed for this study.

The 28 participants in the study could submit only one or as many journals from clinical experiences across the data collection period as they wanted. Three participants submitted three nurse/patient interactions each; three participants submitted two nurse/patient interactions each; and 22 participants submitted a single nurse/patient interaction. Overall, 37 experiences of nurse/patient interactions were described by the 28 participants in this study.

Data collection began at the end of January, 2004. The first ejournal submission was not received until March 7, 2004. During the month of March, only seven submissions were received. The remaining 21 submissions were received between April 2, and April 30, 2004. Because potential participants did not submit data as rapidly as expected, I met with the faculty member who coordinated the students’ Fundamentals course. I had previously met with faculty in January, 2004, during their course planning meeting for the semester to explain my research. The entire faculty was supportive of the research and had subsequently been gracious and welcoming each time I had physically been on campus.

The March meeting with the course coordinator was to elicit ideas for encouraging participation from the individuals who had signed consents to participate in the research but had not yet submitted ejournals of nurse/patient interactions. The course coordinator suggested she change the last required
reflective paper from the semester to include the six questions of this study. All course faculty agreed to change the course assignment to include the study questions; however, the faculty added one question for a summary of the course. The seventh question was “In what ways do you feel your effectiveness in interacting with patients has changed over the course of this school year? What factor(s) do you think has influenced this change?”

The students in the Fundamentals course were told by the course coordinator that the last reflective paper would consist of the questions from my research study. The course coordinator also told the students that the change in assignment was because the faculty believed in the value of the questions and were supportive of my research. To avoid any perception of coercion, the coordinator also made clear to the class that the change in assignment was meant to encourage participation in my research – that as before, students were free to participate or not participate in the submission of data. Students who had not signed consents to participate were given the opportunity to do so if they now wished to participate in the research. The students who had signed consents were encouraged to participate by submitting this last reflective paper both to their individual clinical instructors and to me. No additional consents were signed. Many participants who had signed consents submitted ejournal experiences. After the assignment change, 22 participants submitted a total of 26 nurse/patient interactions.

Because all submissions were made by email, the name of each participant was included. Text was separated from the identifying names of the participants
and I assigned a code number to each participant. If a participant submitted more than one entry, each submission was coded so that all of a given participant’s submissions were kept together. For example, if participant 05 submitted more than one journal entry, the first entry was coded 051 and the second entry was coded 052.

Through analysis of names of the 28 participants, 26 females and 2 males participated in this study. A questionnaire requesting demographic data and past learning experiences was given to all participants at the time the consent was signed; however, only 18 of the questionnaires were completed. The questionnaires were returned without codes or names in multiple instances; therefore, it was not possible to match a questionnaire to a participant. Because 48 consents were signed and only 28 students participated, the 18 questionnaires may or may not belong to any of the actual participants. Due to an inability to connect these questionnaires with actual participants, the responses to the questionnaires were not included as part of the data analysis.

Data Analysis – The Process

The data analysis began when I received the first ejournal submission. I initially read through each submission to become aware of the experience of the participant. The length of each submission was varied. Most of the written experiences were either one or two pages long, double spaced. However, a few submissions were as short as a paragraph, and a few submissions were three or four pages in length. The participants who submitted multiple submissions increased the length of their submissions each time they submitted an experience.
One participant who submitted multiple entries went from a short six sentence paragraph to a four paragraph, richly-described experience.

When each ejournal was submitted, I printed multiple copies to aid in subsequent coding. Each submission was placed into a folder with an assigned number for that submission. I wrote notes about each submission on the outside of the folder, for example, “changing impressions of participant about self and about a patient before and after a bath.” These notes oriented me to the setting of a particular experience. As more and more experiences were submitted, I looked for similarities in thoughts and feelings of the participants. Because data collection occurred across several months of time, I did not thoroughly begin to analyze the data until data collection ended in May, 2004. At that time, I reread the three research questions for the study and listed the a priori categories determined by the literature review. The three research questions of the study were:

1. What is the meaning student nurses make of their experiences in nurse/patient interactions?

2. How do student nurses experience the various levels of presence in nurse/patient interactions?

3. How do nursing students describe being in their nurse/patient interaction?

The a priori categories identified in the literature review were: the science of nursing; the art of nursing; caring; presence; sacred space; and being. The data were analyzed by reading and rereading the participants’ descriptions of their
experiences in nurse/patient interactions while being aware of the research questions and a priori categories. This period of data analysis is called “immersing oneself in the data” (Cohen et al., 2000, p. 76). Throughout this phase of data analysis, I continued to look for words or experiences that illustrated similar themes in nurse/patient interactions.

Finding words or phrases that illustrate themes is key to hermeneutic phenomenological research. Hermeneutic phenomenology, or hermeneutics, is a method of studying “how people interpret their lives and make meaning of what they experience” (Cohen et al., 2000, p. 5). In studying the words and experiences of the participants and looking for similar themes in nurse/patient interactions, I began to analyze how participants interpret and find meaning in nurse/patient interactions.

While rereading the participants’ experiences, I began to label passages and phrases that described similar experiences, thoughts, or feelings. I underlined these passages and phrases in various colors to represent different themes. Cohen et al. (2000) and van Manen (1990) called this phase thematic analysis. The passages that represented similar themes from the a priori categories were cut from the original copy, labeled, and placed together in folders identifying the themes. I then drafted a summary of the narratives from the folders of a priori categories to illustrate the themes. Drafting summaries allowed for identification of themes and enabled me to connect themes at a deeper level than simply continuing to reread original passages. These steps are crucial to hermeneutics, according to van Manen.
As I became immersed in reading drafts of the data analysis, I returned again to the a priori categories. I discovered overlap in many of the categories, for example caring and art overlapped frequently. I then began to code new themes based upon prior themes and the areas of overlap. For example, from the overlap of caring and art in a nurse/patient interaction emerged the theme of connecting with the patient. The themes of this research emerged from rereading the participants’ experiences, coding, and writing multiple drafts of the initial analysis. This chapter represents the findings of the research, including exemplars to support the themes.

Data Analysis – Contextual Impressions

While each submission was unique, two commonalities stood out as I initially examined the data. The first commonality was participant comments about the research. Many of the participants commented directly about submitting experiences for the study. Several participants were hopeful their experiences would help me and would be pertinent to the research. Seventeen of the emails contained comments such as “I hope this helps,” “good luck,” or “I think this will help you.” Even two smiley faces were drawn. The participants also commented about not submitting experiences sooner. Comments such as “I’m sorry it took me so long to respond” were present in six of the email subject lines or bodies of the email submissions. Over 75% of the email submissions had one of the above types of comments in either the subject line of the address or in the body of the email.
The second commonality was the *participants’ expressions of emotion.* Participants expressed much emotion about themselves and about their patients in journaling their experiences, without regard to the length of the submission. Each student demonstrated some emotion or concern through the nurse/patient interactions. Many participants expressed multiple emotions in their experiences of nurse/patient interactions. Four of the six questions to which the participants responded were questions about their thoughts and feelings about the patients and themselves. Obviously, words describing emotions would be expected; however, the depth of the emotions was surprising. Participants expressed the same emotion in similar experiences in the same nurse/patient interaction; participants expressed changing emotions within the same submission. These emotions are discussed throughout the data analysis in the various themes of *being* in nurse patient interactions.

*Data Analysis – Themes and Exemplars*

The purpose of this research was to understand how student nurses make meaning of experiences of *being* in nurse/patient interactions. Through the lengthy data analysis described above, five themes of how student nurses make meaning of experiences emerged. The themes were fear of interacting with patients, developing confidence, becoming self aware, connecting with knowledge, and connecting with the patient. Each of the five themes is discussed in great detail below. The first and second themes, fear in nurse/patient interactions and developing confidence, emerged early in the data analysis. As a
result of reading and rereading ejournals, as well as returning to the a priori categories, the final three themes emerged.

_Fear in nurse/patient interactions._ The strongest and earliest theme to emerge from the data analysis was fear in nurse/patient interactions. The exemplars in this theme demonstrated how anxious and nervous the participants were to interact with their patients. Nervous, scared, afraid, intimidated, frightened, anxious, worried, concerned, and timid were words the participants used to describe how they felt about themselves in the nurse/patient interactions they described. Most of the participants described feeling one or more of the above emotions when walking into the patient’s room or when interacting with the patient. The participants’ experiences of fear fell into three major subthemes: fear of walking into the room; fear of interacting with the patient; and fear of performing a nursing skill.

In the first subtheme, fear of walking into the patient’s room, the participants began feeling fear and anxiety just thinking about going into the room. One participant described her first day on a neurology floor when she “hesitated by the door” due to feeling “very nervous to talk with my first patient on the floor.” Another participant described even deeper feelings of fear and anxiety. This participant was not just hesitant to enter the patient’s room, but went so far as to find herself “rehearsing what I was going to say because I was nervous that I would say the wrong thing.” Yet a third participant described her fear as even more encompassing, listing all the areas in which she felt emotion. She described herself as “too timid to approach an RN, embarrassed to ask anyone a
question, insecure with the patient because I can do so few tasks, and self-conscious the patient thinks I am inept.” Fear and anxiety were so pervasive the feelings existed even in the participants who had experience as nurses’ aides. A student nurse who had previous hospital experience coming into the first year of clinical wrote how different she believed the roles were and that she was “still anxious about being a student nurse.” The fear and anxiety continued for some participants, even toward the end of the semester. A participant described her thoughts and feelings of continued fear when she wrote “Regardless of the expression on my patient’s face or their current attitude, I was always timid to enter a patient’s room.”

The second subtheme to emerge was fear of interacting with patients. Entering the room and beginning to interact with the patients did not always dispel the fear of the participants. These anxious feelings persisted throughout many interactions. One participant described her feelings at the beginning of the semester as “nervous and unsure how to interact with patients” and even after repeat clinical experiences she continued to feel “very uncomfortable, which made it hard for me to properly perform my nursing skills.” Even after multiple interactions with patients, another participant related she was “really nervous to interact with patients. I was afraid I would hurt them or mess something up.” In some instances, feelings from previous clinical experiences persisted into the next clinical experience. One participant was assigned a patient who reminded her of the reserved and distant patient she had cared for the previous week. The participant described feeling embarrassed and timid, and “scared that he would be
like my assigned patient from my previous clinical who did not want a student nurse to care for him.”

Fear and anxiety persisted in patient interactions for some participants, even when the patients were nonthreatening. A participant who turned in a single ejournal described one interaction with a very pleasant patient. This participant discussed how the patient seemed to “benefit from the social and therapeutic stimulus I could provide and as a result I benefited from the satisfaction of meeting her (the patient’s) needs.” Even in this positive scenario, the participant still felt fearful. She wrote this lengthy answer to the question “Any other thoughts or feeling you want to share?”

I’m constantly worried about if I’m doing things right or if the client can sense the often uneasiness I feel. Some new situations are more stressful than others are, but I am of the resolve to force myself to dive into the situations, despite my fear. I know I tend to be clumsy, nervous and awkward at times, but I realize that I cannot be caged by fear. It’s almost as though with every day of clinical I enter this adventurous world where with each task I gain a little jewel or prize for even just doing a simple task like vitals. You could maybe compare it to a Nintendo game like Mario or Packman. Even though there seems to be great pits you may fall into or scary monsters around the corner of intimidation, I need to learn methods to vanquish these fears with actions that are purposeful and effective.

The last subtheme of the fear in nurse/patient interactions theme was anxiety and fear of the first time performance of any skill (e.g., giving a first injection). Giving injections, passing medications, performing a catheterization, and changing a dressing were all described using words like “I was extremely nervous” or “I was afraid I would hurt him.” Affirmation by the instructor, another nurse, or the patient assisted the participants to feel positive about the accomplishment of one of these nursing skills. A participant wrote of her first
experience doing a catheterization and the positive affirmation from her instructor, “I was fairly nervous at first because I had never done a catheterization and I was afraid of hurting him, but I did what I had to do, and I did it right.”

In some first-time skill experiences, the patients themselves helped the participants overcome fear. One participant wrote about an interaction with a pregnant patient who was diagnosed with appendicitis. The participant wrote extensively about her thoughts and emotions of this acute situation, particularly her fear in interacting with such an ill patient. This nurse/patient interaction was the first time the participant had to perform a thorough assessment on someone acutely ill and to assess and treat the patient’s pain. The patient actually comforted the participant while the participant watched the nurse give the IV pain medication to the patient. The participant wrote how “so much was going on at one time yet the patient still remained calm, collected, cooperative,” which also decreased the participant’s fear.

In contrast to the above exemplar, patients occasionally increased the anxiety of participants. A participant described how she gave a patient two oral medications, and then told the patient she would give him an insulin injection. In this exemplar, the patient added to the participant’s anxiety in giving her first injection. The participant related the patient was “very nervous about me giving him his injection because he knew I was a student” and repeatedly asked the instructor if the student was doing everything right. The participant recalled, “I was very nervous and I wanted to make sure I did the injection properly.” The
injection went perfectly according to the participant. In this exemplar, the
experience of increased anxiety was short lived.

In comparison, another participant experienced prolonged fear during an
extended interaction with her patient. An extremely overweight patient was
hospitalized for many health issues and the participant was to assist the patient
with a shower. Truly fearful she would hurt the patient, the depth of fear was
almost palpable in the participant’s ejournal. The participant wrote that before the
shower she was “a little nervous because the patient had a lot of trouble standing
and was very overweight.” The patient became “very weak while standing in the
shower” and the participant’s fear reached its peak as she had to call out for
“someone to run and get a chair for me.” The participant wrote she was able to
wash the patient’s hair and assist her with finishing the bathing. Describing the
walk from the shower to the bed, the participant wrote she was “nervous the
patient would fall.” Through taking time and moving slowly, the patient was
safely returned to her bed without incident. Reflecting back upon the experience,
the participant stated “I was concerned that I wouldn’t be able to handle the
situation by myself if she were to have any more trouble in the shower."

*Developing confidence.* The second theme that emerged from the
participants’ experiences in nurse/patient interactions was developing confidence.
Over two-thirds of the participants discussed developing confidence and/or
feeling confident in their abilities and in their interactions with patients. Three
subthemes emerged in developing confidence: an increase in confidence from a
successful skill implementation (science), using a successful skill implementation
to increase confidence in a patient interaction, and an increase in confidence from a single patient interaction (art).

The first subtheme is evident in participants’ descriptions of how they began to develop or did develop confidence after a successful skill implementation. Many times, a participant achieved confidence through successful completion of a nursing skill (e.g., a first injection, a dressing change). After giving oral medications for the first time, one participant described how she began to develop confidence. The participant wrote “I felt confident with passing meds,” however, she qualified she would not feel as confident “if my clinical instructor was not by my side simply because I do not have that much experience yet.”

In another exemplar, the first time a participant removed a catheter from a patient’s bladder she wrote about the confidence she gained and gushed, “I love gaining experience, so any little job increases my enthusiasm for nursing.” A patient who required complex nursing skills helped another participant experience a one-time boost in confidence. The participant described successful performance of multiple skills with a patient - took vital signs, gave a bath, provided oral care, catheterized the bladder, and cleaned the Gastrostomy-tube (G-tube) into the patient’s stomach as well as gave medications through the G-tube. After all these skills were completed successfully, the participant wrote “This experience gave me so much confidence about my ability to give competent care to patients.” In these exemplars, the participants began to or did develop confidence just through successful skill implementation.
In comparison, in the second subtheme, using a successful skill implementation to increase confidence in a patient interaction, the participants not only demonstrated success in performing nursing skills but also used the skill as a vehicle to interact with a patient. The patient interaction was from where the true confidence emerged, not from successfully completing the skill. These one-time skill implementations allowed the participants to connect with the humanness of the patients.

An exemplar of the second subtheme occurred with a participant caring for a male patient. The patient taught the participant about Coumadin, a medication prescribed to thin the blood. The patient also taught the participant the name of the laboratory test to monitor his medication and what blood levels were acceptable. Giving medications and having knowledge of appropriate laboratory value monitoring are science of nursing skills. The participant wrote “after spending a short time with the patient, I felt surprisingly comfortable and more confident in my skills as a nursing student.” The uniqueness of this patient teaching interaction was further illustrated when she shared that she typically preferred female patients because “I tend to be more timid around male patients.” Confidence and connection developed over this one-time interaction with a patient who would normally be intimidating to the participant.

Another participant developed confidence through learning a new skill from her patient. This participant described her “intimidating experience” with a patient and the physical sensations of first touching his fistula, a surgically-created blood vessel used for dialysis. The patient taught the participant how to
listen for the flow of blood and how to palpate the pulsation in the fistula, both normal nursing skill assessment activities. The participant wrote “During this interaction, I initially felt unknowledgeable and lacked confidence in myself. The patient actually had more medical knowledge than I did.” Upon reflecting back on the experience, the participant focused on the recognition of the patient interaction and connection with the patient. She wrote “I felt grateful for his patience and willingness to help me learn. He boosted my confidence by telling me that he wanted to help me become a knowledgeable and experienced nurse.”

The last subtheme in developing confidence, an increase in confidence through a one time-patient interaction, began to reflect the concepts of being and the art of nursing. Developing confidence was especially a challenge for participants when interacting with patients who could not verbally communicate. A participant expressed great emotion relating how she developed confidence through caring for a patient who not only was unable to verbally communicate, but also demonstrated negative body language to the participant. The participant explained the patient “was glaring at me the whole time I was talking” and when asked if she needed anything, the patient “just pointed with her left hand and continued to glare viciously at me.” The participant attempted to discover exactly what the patient wanted by picking up objects or pointing and asking if that was what the patient wanted. The participant was unable to determine what the patient wanted and stated “I didn’t know what to do. I even questioned if I should be in nursing.” When the participant told the nurse assigned to the patient about the interaction, the nurse giggled and stated the patient always glares and points for
no reason at all. The nurse explained the patient had experienced a stroke and these were common symptoms a patient may have after a stroke. The participant wrote that the rest of the day went smoothly and she experienced a growth in confidence after the day with the patient. The participant stated she “got along well with her and felt more fulfilled than I could have imagined” after the one-time experience. The nurse in this exemplar gave the participant an external verification of how to attempt to experience being in interaction with this patient.

Developing confidence occurred in a deeper level of connection in a nurse/patient interaction for another participant. In this interaction, the participant was interacting with a very quiet, noncommunicative patient, who “made it a challenge to get a conversation out of her.” The participant persisted with her interaction, performing the nursing assessment, providing the morning care, and continuing to talk with the patient. At one point in the interaction, the patient really opened up to me and made me realize how appreciative she was that I was there helping her. She thanked me many times for all the little things I did for her and felt comfortable enough to tell me about personal experiences.

The participant described how she felt more confident and comfortable as the patient “gained trust in me which made it easier for our interaction.” The nurse/patient interaction made an impact on both patient and participant.

**Becoming self-aware.** A theme that recurred with participants was becoming self-aware. In this theme, participants experienced a nurse/patient interaction that resulted in self awareness. The participants who became self-aware did so through reflection, and found meaning in who they were as nurses. Participants discovered self-awareness through one of four kinds of reflection:
reflecting upon their thoughts; reflecting upon an interaction with a patient; comparing their thoughts to the actions of another nurse; or seeing inner role conflict.

The first type of reflection in becoming self-aware, reflecting on thoughts, occurred for one participant when she described a time she had been a patient herself. Relating to her experience as a patient allowed this participant to connect to self as a nurse. The participant stated, “I feel I can better put myself in the patient’s shoes. This allows me to immediately understand how my patient wants to be treated.” This participant knew how she wanted to care for patients based upon her own thoughts and experiences. The process of thinking about thinking occurred with another participant who was caring for a patient diagnosed with cancer. In this exemplar, the participant became self aware of how she will function as a nurse while thinking about her patient. The participant wrote “How would I react if I was diagnosed with cancer? I think I will always react emotionally to all these patients.” Both participants began to be aware of how they will function as a nurse through thinking, and experienced an “aha” in becoming self-aware.

The second type of reflection, reflecting upon an interaction with a patient, also resulted in the participant becoming self aware. One participant began to understand herself after providing care for a patient with Alzheimer’s dementia. In reflecting upon her interaction, the participant was surprised at how strongly she wanted to provide care for patients who had Alzheimer’s dementia. The participant wrote:
I have a strong desire to help those in need no matter what age or level of mental stability. Looking at my patient in a state of mind that she can’t control seemed to touch a special place in my heart. My interest and desire to do so much for this patient really surprised me.

The participant continued her reflection by discussing thoughts concerning her grandmother, who has Alzheimer’s dementia.

Having watched my own grandmother at one point in that state must have added a more realistic appreciation for those that care for the elderly. I have never had a strong desire to work with the elderly but to know that I possess the skills I feel are important and essential for good elderly care makes me feel happy to do for others what I couldn’t do for my grandmother.

Another participant experienced the subtheme of becoming self-aware though her reflection on a patient. The participant described the patient as “tired,” and discovered the patient was not responding to her assessment questions because “it was very evident that these questions had been asked by numerous other health care workers.” After helping other nurses with patient care, the participant returned to her patient and asked if he wanted a shower and linen change on his bed. The participant described how “I have never seen anyone’s face light up as much as his did with that simple request. He was so thankful for the little extra care that he offered me a tip.” Self awareness occurred as the participant reflected on the situation, stating “I was too quick to judge and make first impressions. I assumed that the patient wanted to be left alone, but in reality he just wanted someone to pay attention to him.” Self-reflection allowed this participant time to clearly see not just her patient, but herself.

The third type of reflection in becoming self aware, comparing thoughts to the actions of another nurse, led to reflections about how a participant will
function as a nurse. One exemplar demonstrating this type of reflection occurred when a participant had cared for a patient with scabies – an organism that causes open sores and scabs that are painful, itchy, and very contagious. These patients are always in isolation and often have this disease from poor hygiene. The participant reflected on the judgmental nurses on the unit who were discussing this patient, “Although some nurses lack the basic need for compassion, I refuse to become one of them. I realize the road to becoming a superb nurse is not an easy one.” A similar exemplar was described by a participant who cared for a drug abuser. This participant wrote, “health care providers have biases toward him and his past. I would not want to be one of those people, and I would want to know his side.” Both of these participants reflected on self awareness and learned the importance of remaining nonjudgmental toward their patients.

The last type of reflection for becoming self aware, seeing inner role conflict, was described by two participants. These participants experienced dissonance in comparing their individual personalities to the characteristics needed to “be” a nurse. The first participant realized she was still unsure of her role as a nurse and described her inner conflict. “I’ve realized that even though I consider myself to be a friendly person who cares about helping people, it doesn’t mean this personality extends as forcefully into the nursing setting yet.” The second participant was “hit on” by her patient who was old enough to be her father. The participant’s initial response to the patient was “a comment about dividing my professional and personal life.” The participant’s self awareness is shown when she relates “What I really should have said was ‘this is making me
very uncomfortable’ or ‘I need to take care of you today to make sure you are safe but that is as far as it goes’.” She continued to say she believed her reaction to patients like this will come with experience. Both of these participants were becoming aware of how they wanted to “be” as nurses after reflecting back upon their experiences.

Connecting with knowledge. Another theme that emerged from the data analysis was connecting with knowledge. An a priori category was the science of nursing – the skills, knowledge, and content of nursing. These participants described the science of nursing as the knowledge needed to be a nurse and wrote how they connected with the knowledge of nursing. Two subthemes of knowledge emerged – connecting with classroom knowledge and connecting with the performance of nursing skills.

In connecting with classroom knowledge, a participant was aware of an aspect of nursing science or knowledge that allowed the participant to understand how to function in an aspect of nursing practice. In an exemplar of connecting to classroom knowledge, a participant identified how initially she only felt comfortable by talking to patients about general topics. “At the beginning, I could only connect with patients by talking with them.” The participant identified part of her struggle was to “provide real care and actually perform tasks other than verbal communication.” Connecting to classroom knowledge was the key to patient care for this participant. The participant wrote, “I have gained extensive knowledge about pathophysiology, human anatomy, pharmacology, assessment,
and much more. This knowledge has given me the confidence to sit down and talk with a patient without worrying about what questions they may ask.”

A similar connection to knowledge was identified by another participant. The difference in the following exemplar was the participant’s connection of knowledge at the higher cognitive level of synthesis. This participant wrote about individual patient differences, stating “when communicating with patients, I know more about the body and illnesses, different cultures and their preferences in health care, and how to properly respond to some of the problems patients discuss with you.”

Some participants were even more specific in knowledge connection, through exemplars of knowledge application to individual patient situations. One participant made a knowledge connection from an interaction with her patient. In this exemplar, the participant connected classroom knowledge to her assessment of her patient, specifically connecting to knowledge concerning activity and rest patterns. The patient described how he needed to get up to go to the bathroom every few hours during the night. The participant noted that the patient looked very tired, and asked the patient if he felt tired. He responded yes, although he did not know why he was tired and was unsure how to improve his sleep patterns. The participant realized she connected to classroom knowledge when she concluded that the patient’s enlarged prostrate caused frequent urination during the night, and interrupted his sleep. The participant stated “I felt positive about myself and proud.”
In the second subtheme, connection of knowledge through performance of nursing skills, a participant described how she applied in general the knowledge and skills taught in lecture and lab to the fullest potential in the clinical setting. She wrote, “I feel that I have become much more efficient in my physical assessments, performing them completely and quicker with an emphasis on the organ systems that will be affected most by the patient’s condition.” Some participants connected to knowledge through performing a specific skill, such as giving an injection or inserting a catheter into a bladder. Although student nurses traditionally practice such skills in a learning laboratory on mannequins, using specific steps taught by instructors, performing the skill on a real person was real nursing practice. One participant described how real-world nursing occurred in her exemplar of performing a dressing change on her patient. The participant related, “I felt good because I was interacting as a real nurse and I was helping. I was also proud of my dressing change.”

Some participants went so far as to connect both skills of nursing and classroom knowledge in the same patient interaction. For one participant, the connection of classroom knowledge to nursing skills was learned from observation of a nurse as well as through actual participation in skills herself. This participant watched a nurse insert an intravenous catheter, or IV, into a 300-pound Navy veteran’s arm. An IV catheter is a large needle inserted into a vein by a nurse. After the IV was inserted by the nurse, the participant used a smaller needle and syringe to inject a medication into the patient’s abdomen. The participant described her connection to skills by being pleased with the success of
her injection. She continued to reflect that the patient’s reactions to both
injections likely demonstrated a fear of needles. The participant wrote, “When I
gave him the injection, his reaction made me wonder if I was doing something
wrong because subcutaneous injections don’t hurt that much. Then I began to
ponder the issue of pain tolerance across age, gender, and culture. He probably
hated needles.”

*Connecting with patients.* The theme with the most supportive exemplars
was the theme of connecting with patients. Participants wrote story after story of
connecting in various ways with their patients. As defined in chapter one, the
essential core, the heart of nursing, is the nurse/patient interaction, where the
nurse experiences nursing (Appleton, 1994; Chinn & Watson, 1994; Johnson,

One of the more dramatic exemplars of connecting with a patient occurred
when a participant was assigned a patient who could not talk. The participant
wrote

> It was exhausting trying to communicate, asking her questions over and
> over again until she responded with a simple nod or grumbling noise. Her
disability did not seem to hinder her. She smiled most of the time and
would show me awkward faces just to make me laugh. Despite the
discouragement of the communication barrier, we still communicated
physically. The actions in her face made it kind of like a guessing game to
what she was thinking. In the end, the situation improved dramatically.

In this exemplar, the connection between participant and patient occurred without
words. The words of the experience from the participant’s view told a story of
connecting without verbal communication and demonstrated how important
connection without words can become in nursing practice.
Participants connected with patients in varied situations. In the above illustration, a connection occurred through smiling and facial gestures. In the next exemplar, a participant not only experienced connections through the patient’s smiling and facial gestures, but also internalized the interaction to find meaning in the gestures. The participant wrote of her very “gratifying” day in caring for her very ill, dependent patient. She described

When I went to leave, even though my patient could not talk he made me feel like he had faith in me. When I went to say ‘goodbye and thank you’ for letting me care for him, his eyes looked up, as if to say, ‘Oh, you’re leaving so soon?’ He then half smiled and waved.

One participant connected with her patient through gestures, but also through the patient’s words. The participant was assigned a quiet female patient who was “a challenge to get a conversation out of her.” Through her interactions with the patient across the day, the participant gained the patient’s trust and connected with the patient.

The look in her eyes when I did just the simplest tasks, like bathing and feeding her is unforgettable. And she really made me feel special by the very nice comments and thank you’s after each activity. Not only did I feel like I made a difference in her life, I felt like she made a difference in mine.

Many participants connected with patients through talking with the patient. In an exemplar of connecting through talking, one participant learned that just because a patient was distant did not mean the patient did not need help. This participant shared an interaction with a patient who was frustrated with her hospitalization. When the participant asked her if there were any stressful events in her life beyond her hospital stay, the patient opened up. The patient’s daughter had recently been diagnosed with cancer, and the patient became very tearful and
described her guilt in being unable to care for her daughter. “I could tell that
getting her feelings off her chest and admitting that she felt guilty and depressed
helped her feel better about the situation, especially when a healthcare provider
could validate those feelings as normal and healthy.” The participant continued,
“I have noticed my ability to interact with patients has tremendously improved. I
now feel comfortable in one-on-one situations. I have the ability to make a
difference in the lives of my patients.”

As participants experienced connections with patients, reflections began to
become deeper and more comparative of various nurse/patient interactions. One
participant described her most recent interaction with a patient and compared this
interaction to her previous patient interactions. “I felt the client was caring,
interested in being rehabilitated, and engaged with the conversation and
assessment I performed.” The participant was happy to have connected with this
patient, as her previous experiences with patients had not resulted in the same
kind of connection. She wrote

At times I feel like I relate to some patients as if they are lab rats strictly to
be used so I can learn from them. It makes me sad afterwards because I’d
like for them to know I value more than what they are physically.

Through reflection, this participant began to understand nurse/patient interactions
through the connections nurses make with patients.

As participants began to have multiple patient interactions, the
connections with patients occurred through more unique situations. One
participant wrote of caring for a patient who had difficulty talking from a stroke.
Through persistence, the participant connected with the patient and understood
what the patient was trying to communicate. Other health care professionals had not understood the patient was upset that her teeth did not feel clean. The participant understood the patient was upset that the sponge to clean the patient’s teeth was not “minty” enough. The participant wrote

"Although the conversation took a while because of my difficulty understanding her, I finally understood how it meant a lot to her if I would clean her mouth thoroughly. After I finished with her teeth she expressed how she felt much better and how she could taste the mint. Through her facial expression I was able to see how much she appreciated my time in trying to understand her and thoroughly cleaning her teeth and mouth. I felt I was making a difference in this patient’s life even though it was very minor compared to the difficulties she was going through with her stroke."

Lastly, participants experienced connections with patients who were engaged in the nurse/patient interaction but would later have no memory of the experiences. One of the participants was caring for a patient with Alzheimer’s dementia and connected with her patient through their time together. The participant wrote

"I felt like my patient was in need of time, compassion, conversation, and care. Despite the fact that I knew she wasn’t going to remember much of what we talked about or even know who I was it made me happy to see her smile and laughing while we were talking. Overall I believe that I made her happier by just taking good care of her and making sure that she was warm and comfortable."

*Experiencing sacred space.* Through the participants’ interactions with patients in multiple clinical experiences, they shared narratives of these experiences. Some participants experienced situations as nursing students that moved beyond the experiences described in the other five themes. When one participant truly touched the humanness in herself *and* in the patient, the participant experienced sacred space of nursing. The exemplar of one participant
suggests the possibility of a sixth theme – experiencing sacred space. While many participants experienced a connection with a patient, the fifth theme, this participant’s experience suggests the deeper connection found in the experience of sacred space.

The next two exemplars are illustrations of these different participants’ experiences of connection with a patient. The first exemplar is a participant’s description of a simple connection with a patient, and is illustrated as a comparison to the second exemplar, when a participant experiences sacred space. In the first exemplar, the participant discussed the struggle to get her patient to interact with her. The patient did not want to have anyone in his room, wanted to be left alone, and did not initially want to talk to the participant. The participant wrote:

The feelings I had toward the patient during the interaction parallel the feelings I had about myself. I have to admit that I was initially disappointed to have Mr. [Name] assigned as my patient because he expressed annoyance at my presence. I was nervous that it would be a negative experience and very difficult to ask and question the patient due to his lack of interest and cooperation. However, as I performed my assessment and began a conversation with him, I gradually developed a more positive attitude towards him. He became more talkative, causing me to be more interested in what he had to say.

In this exemplar, the participant was eventually able to connect to the patient after an uncomfortable beginning. The interaction with the patient did not progress beyond the theme of connection with patients with the participant. In comparison, the next exemplar is a narrative of a nurse/patient interaction moving beyond connection to the theme of experiencing sacred space:

I have had nothing but positive clinical experiences this year, but there is one experience that sticks out in my mind more than any other. It was a
situation that occurred with a patient that I was not assigned to but was helping out while my patient slept. I do not even know the patient’s name, nor do I know her diagnosis or medical history because I simply helped her bring her things to her car after being discharged home. In the few minutes that I was able to talk to her, however, she touched my life and reminded me why I decided to become a nurse.

The woman was a nurse who worked at the [Name of] Hospital but was hospitalized for elective surgery. Her and her husband were packing up her belongings and asked me for help bringing everything down to their car. As I wheeled the woman downstairs, it became apparent that her husband was having trouble keeping up beside us. I slowed down to his pace and noticed that he was breathing heavy. He assured me that he was okay and struggled to keep up his pace. When we arrived at the hospital entrance, I stayed with the woman while her husband went outside to get the car. As the woman watched her husband walk away, I noticed that she was trying to fight back tears. She told me that her husband had just been diagnosed with prostate cancer and it upset her to see him struggling. She told me the story of his diagnosis and said that he had decided to wait to start his chemotherapy treatments until after her surgery so that he would be strong enough to take care of her. She told me that he was a wonderful man and did not deserve the pain and suffering that he had been going through recently and expressed that it hurt more than anything that she couldn’t do anything to stop his pain. I was touched at how close and loving they were.

I tried to be empathetic and understanding with her feelings of guilt and sadness. When she apologized to me for crying I told her that it was okay to cry and express her feelings and I gave her a hug. I knew that she was trying to be strong for her husband but needed someone to cry with and share her feelings with.

She then looked to me and saw the tears that were collecting my eyes and told me that I was going to make a wonderful nurse. She told me that she had been a nurse for thirty years and even though she had only spent a mere five minutes with me, she knew that I had the qualities it took to be a great nurse. Hearing her say these words made my day. There are so many tasks that nurses do and we often forget that it is the little things that count the most. We forget that listening and offering a hug means more to most patients than the daily tasks that we often consume ourselves with. In those five minutes of talking with her about her husband’s condition, I had touched her life. More importantly, however, she touched mine because she reminded me how rewarding a career in nursing can be.

Experiencing sacred space is touching yourself and your patient in the
pure humanness of the moment. The connections that occur in nursing are at times beyond words. I believe more research may verify this theme as experienced by student nurses.

In conclusion, the data collection for the study occurred over four months, or one college semester, with sophomore nursing students. The participants described experience in nurse/patient interactions, and five themes emerged from the data. The themes are connected to the a priori categories in chapter five. Chapter five includes a discussion of the findings and includes recommendations for future research.
Chapter 5
Summary, Discussion, Conclusions, and Recommendations

One thing in common with all patients is that they want you to listen to them, be with them, empathize with them, and really take out some time to sit next to them and be with them. (Study participant, 2004)

Good teachers possess a capacity for connectedness. They are able to weave a complex web of connections among themselves, their subjects, and their students so that students can learn to weave a world for themselves. (Palmer, 1998, p. 11)

The final chapter consists of a summary of the results of the study; a discussion of findings of the study, including their relationships to the research questions; conclusions and implications; and recommendations for further research. The summary includes the purpose of the study, the statement of the problem, and the research questions that guided the study. The discussion highlights the findings, as well as ties the findings to the research questions and literature review. The research questions are explored and discussed in relationship to the themes from the data analysis. The conclusions of the study are discussed, and the implications in relationship to nursing education are presented. Finally, the recommendations for future research are given.

Summary

The purpose of this study was to discover how student nurses experience being and presence in nurse/patient interactions. The purpose was defined based
upon a thorough review of the literature and the identification of gaps in the educational experience of student nurses related to the art of nursing. The literature review demonstrated a lack of knowledge in the field about how student nurses learn the art of nursing, or the art and science of nursing in authentic nurse/patient interactions. This gap in the literature led to the statement of the problem: *Nurse educators do not know or understand how student nurses make meaning of experiences of “being” in nurse/patient interactions.* Three research questions were designed to address the problem:

1. What is the meaning student nurses make of their experiences in nurse/patient interactions?
2. How do student nurses experience the various levels of presence in their nurse/patient interactions?
3. How do student nurses describe *being* in their nurse/patient interactions?

The participants in this research were undergraduate nursing students at a midwestern Carnegie extensive doctoral/research institution. These students were sophomores in college and enrolled in their second nursing course involving clinical experiences with patients. The participants ejournaled selected experiences from their nurse/patient clinical interactions. The participants recorded their thoughts, feelings, and emotions of *being* and presence in interactions with patients through these self-selected clinical experiences across a semester of their nursing education.
Through Hermeneutic data analysis, five themes emerged of how student nurses experienced nurse/patient interactions. The themes were fear of interacting with patients, developing confidence, becoming self aware, connecting with knowledge, and connecting with the patient. Each of the five themes was discussed in detail in chapter four, including exemplars of the participants’ experiences. A sixth theme, experiencing sacred space, was seen through one participant’s experience with a patient. To understand the findings, the discussion section relates the findings to the literature and research questions.

Discussion of the Themes

The purpose of the study was to discover how student nurses experience being and presence in nurse/patient interactions. The participants e journaled 37 nurse/patient interactions, and through analysis of the journal data, five themes emerged. In order to relate the five themes to the research questions, the definition of three terms from the research questions should be recalled—meaning, presence, and being. Meaning is the feelings, thoughts, and perceptions an individual has in an experience. Meaning is the organization of what happens to an individual; it is to make sense of what happens (Benner & Wrubel, 1989). Meaning is an interpretation of an experience, and the meaning of a same experience will likely be interpreted differently for each person. Meaning comes from within each individual.

Presence is the physical and psychological being of the nurse with the patient to meet the patient’s health care needs (Gardner, 1985). Presence is experienced and can be described by the individual; yet presence can also be
described by an outsider watching two people interact. In comparison, both *being* and meaning are subjective and only known as told by the person experiencing the interaction.

*Being* is a process or activity of existing - looking back at an experience that has occurred to fully understand the process (Heidegger, 1962). As an individual describes *being*, a part of the description may include the interpretation of the experience, or the meaning. Therefore, meaning and *being* are similar, yet different. Meaning is an interpretive process of an experience, whereas *being* is a reliving of a situation as it occurred – a description of what it was like to be in a given situation. Another way of separating the definitions of meaning and *being* is to say meaning is an interpretation, *being* is a description – both of the same lived experience. Many of the nurse/patient interactions illustrate the importance of the differences of meaning and *being*. It is through the reliving or reflecting back upon an experience – the *being* – that sense is made of the experience – the meaning. The journal entries of the participants in this study indicate they experienced meaning, presence, and/or *being* in their interactions with patients.

One exemplar that distinguished among meaning, presence, and *being* was one participant’s experience of a patient “hitting on” her. In her narrative, the participant described her patient’s medical problems and how he taught her about his medications. The participant then described taking her patient to the hospital lobby to get a newspaper and bringing him back to the sunroom to “soak up the sunlight.” As they talked in the sunroom, the participant described how the patient began “hitting on” her.
He told me a woman hasn’t made him feel like I have in 10 years and on
and on. He asked me out to a soda or coffee. As he was saying all this I
felt more and more embarrassed and uncomfortable. This man was as old
as my father.

The exemplar described above demonstrates being in a nurse/patient interaction –
a reflection back on a process or activity of existing – a description. The reflecting
back and reliving the experiences – describing a man her father’s age who was
interested in her as a woman when she was in the role of a student nurse – was an
experience of being in the situation. Throughout the exemplar, the participant
described the active engagement of the patient with her in the interaction, which is
an interaction illustrating full presence to one another. Full presence occurs when
the nurse is fully open to the patient and performs intentional acts of care
(Osterman & Schwartz-Barcott, 1996).

The meaning illustrated in the exemplar is when the participant makes
sense out of what happened in the interaction, or interprets what occurred. Her
statement that “I felt more and more embarrassed and uncomfortable” in the
above exemplar is her meaning, or interpretation of what she experienced. The
participant further describes the meaning of her experience:

When he was done, I had to reply. I really just wanted to run away. I
made up some line about dividing my professional and personal life. What
I really should have said was “this is making me very uncomfortable” and
took him back to his room. I felt like I was compromising my rights as a
woman when trying to save the embarrassment of both him and I. This
situation was very awkward, uncomfortable, very hard and unexpected.

The participant found meaning, or made sense of this situation, when she
described how she felt in the interaction. This participant interpreted the patient
“hitting” on her as a conflict between how she experienced being a nurse and
being a woman. This exemplar illustrates meaning, presence, and being as experienced by the participant. Meaning, presence, and being each represent the focus of a research question for this study, and the research questions are answered through the emerged themes.

In the themes of the analysis described in chapter four, the meaning, presence, and being of the participants were merged. Therefore, exemplars are used in this discussion section to illustrate meaning, presence, and being. One of the research questions was “How do student nurses experience the various levels of presence in the interactions with patients?” This research question was answered when any of the levels of presence was easily identifiable in a participant’s exemplar; however, in many instances, the specific level of presence was difficult to ascertain from the participant’s written description. Presence would have been more easily determined with mixed method research; for example, I could have included participant observation in conjunction with asking the participant to journal the experience. Determining levels of presence will be addressed in the future research section later in the chapter.

The first theme, fear of interacting with patients, was pervasive across the experiences of the participants. Fear of interacting with patients was a way the participants described experiences of being in nurse/patient interactions. One answer to the research question “How do student nurses describe being in their nurse/patient interactions” is fear of interacting with patients. Experiencing fear of interacting with patients was a common way of being for a nursing student in the first semester of interacting with patients. Some participants experienced such
fear that they couldn’t even walk into the patient’s room – in those instances, fear stopped both physical and psychological presence. When experienced, fear blocked the participant from interacting with the patient.

The theme of fear of interacting with patients also relates to the second research question, “How do student nurses experience the various levels of presence in their nurse/patient interactions?” Presence in this study was defined as “the nurse’s physical being there and the psychological being with a patient for the purpose of meeting the patient’s health care needs” (Gardner, 1985, p. 317). In order to experience full presence, the student nurse must be physically and psychologically with the patient. If the student nurse stands outside the room and experiences fear of walking in the room, physical presence does not occur. Even when the student walks into the room, the psychological presence of “being with” the patient will be compromised until the student nurse can move her focus from self to the patient. Until fear or anxiety are confronted and resolved, a student nurse will have difficulty experiencing psychological presence with the patient. Therefore, when fear of interacting with patients existed, physical presence was difficult to achieve, and psychological presence occurred even less frequently.

The second theme, developing confidence, was lived throughout the participants’ experiences. Participants described developing confidence after reflecting back on an interaction with a patient. Being was, at times, described as developing confidence - an outcome of the interaction with a patient. In addition, the participants interpreted, or found the meaning of the interactions, as developing confidence. Therefore, the second theme of developing confidence
answered the research questions, “What is the meaning student nurses make of their experiences in nurse/patient interactions?” and “How do student nurses describe being in their nurse/patient interactions?” The key to developing confidence for these participants was through experiencing successful skill implementation, through simply interacting with a patient, or through a combination of successfully completing a skill while interacting with the patient.

An exemplar illustrating how confidence developed was presented in chapter four when a participant described her “intimidating experience” with a patient and the physical sensations of first touching his fistula, a surgically-created blood vessel used for dialysis. The patient taught the participant how to listen for the flow of blood and how to palpate the pulsation in the fistula, both normal nursing skill assessment activities. The participant described how it was to experience being in the interaction when she wrote, “During this interaction, I initially felt unknowledgeable and lacked confidence in myself. The patient actually had more medical knowledge than I did.” Upon reflecting back on the experience, the participant focused on the meaning of the patient interaction when she wrote, “I felt grateful for his patience and willingness to help me learn. He boosted my confidence by telling me that he wanted to help me become a knowledgeable and experienced nurse.” The participant realized that confidence developed as an outcome of her interaction with the patient.

Presence was also experienced in the above nurse/patient interaction. The participant physically and psychologically provided care to the patient. While the participant physically touched and listened to the patient’s fistula, the patient
psychologically shared how he wanted her to become a good nurse. The second research question, “How do student nurses experience the various levels of presence in their nurse patient interactions?” was answered through the exemplars of developing confidence. Participants experienced physical, partial, and full presence in nurse/patient interactions. The fourth level of presence, transcendent presence, or sacred space, was experienced only by one participant and will be discussed further in the chapter.

Becoming self-aware, the third theme of the data analysis, flows from developing confidence. As with the second theme of developing confidence, participants became self aware through reflecting back on experiences in nurse/patient interactions (the being) where the participants uncovered the meaning of the interaction. Participants discovered self-awareness through one of four kinds of reflection: reflecting upon their thoughts; reflecting upon an interaction with a patient; comparing their thoughts to the actions of another nurse; or seeing inner role conflict. For example, one participant connected to herself as a nurse by reflecting back on her experience as a patient. The participant stated, “I feel I can better put myself in the patient’s shoes. This allows me to immediately understand how my patient wants to be treated.” The reflecting back – how it was to be a patient – allowed the participant to discover self. The reflecting back on thoughts was the experience of being; the knowing of how she wanted to be as a nurse was the meaning the participant discovered.

One participant illustrated a different subtheme of becoming-self aware when reflecting upon an interaction with a patient. Initially in the interaction,
patient wanted to be left alone. A few hours later, when the participant returned to assist the patient with his bath and change his linen, the patient wanted the nursing student to provide care. Self awareness occurred as the participant reflected on the situation, stating “I was too quick to judge and make first impressions. I assumed that the patient wanted to be left alone, but in reality he just wanted someone to pay attention to him.” Self-reflection allowed this participant time to see clearly not just her patient (what the patient really wanted was attention), but also herself (she judged and made first impressions too quickly). Through reflecting back upon the interaction (the being) the participant found meaning in the experience.

In the fourth theme, connecting with knowledge, participants described the science of nursing as the knowledge needed to be a nurse and wrote how they connected with the knowledge of nursing. Two subthemes of knowledge emerged – connecting with classroom knowledge and connecting with the performance of nursing skills. In connecting with knowledge, participants demonstrated how they apply their cognitive learning to the practical experiences of nursing practice. This theme connects to all three research questions of how the participants experience meaning, presence, and being in nurse/patient interactions.

Originally described in chapter four, the exemplar of the participant and the 300-pound patient who feared needles illustrates meaning, presence, and being through connecting with knowledge. The participant described giving a subcutaneous injection and watching a nurse insert an intravenous catheter into the patient. The participant experienced partial presence by being physically
present when the RN started the IV – the participant watched and observed the patient. The student was fully present with the patient while talking with the patient as she gave an injection – aware of his reaction psychologically as well as through physical presence. The participant experienced being through reflecting back upon the experience – describing how it felt to give the injection and how the patient reacted to the two different needle injections. The participant concluded, “He probably hated needles.” This quote illustrates meaning – the participant connected her knowledge of fear of needles through the patient’s reactions and classroom knowledge of how patients react who fear needles.

The fifth theme, connecting with patients, is how the participants described the meaning, presence, and being they experienced with patients. Connections occurred without words, with words, and though a variety of patient interactions. Through connections with patients, the participants made sense or meaning of the feelings, thoughts, and perceptions in these patient interactions.

The exemplar in chapter four, describing the participant who connected with her patient through understanding that the patient’s mouth was not clean, nor “minty” enough, demonstrates physical and psychological presence, being fully present with the patient. Other health care professionals had not understood the patient was upset that her teeth did not feel clean. The patient could not verbally communicate because of a stroke.

The participant described the struggle to understand what the patient was trying to communicate, and described how cleaning a patient’s mouth taught her the importance of satisfying a patient’s needs. The participant’s description of
this interaction illustrates being – reliving the physical care and time to help this patient to have a clean mouth. The participant understood that the patient had many physical problems related to the stroke. She connected with her patient to make sense of what the patient needed. The meaning occurred when the participant understood the importance to the patient of the physical care of her mouth.

To be a nursing student is to begin to connect with patients. Because so many of the nurse/patient connections described by the participants answer all three research questions, the exemplars of the theme connecting with patients illustrate how nursing students experience being, meaning, and presence. Through all five themes, being and meaning were identified. In the literature review discussed in chapter two, an even deeper level of connection exists with nurses called transcendent presence, or sacred space. The experience of one student suggested that student nurses can experience scared space, where meaning, being, and presence all exist simultaneously in a oneness between nurse and patient.

Implications for Policy and Practice

Fear of interacting with patients. The implications for nursing education became clear based upon the themes uncovered and a return to the literature review in chapter two. The theme of fear of interacting with patients was not identified in the literature review, where much of the focus of research has been on the science of nursing education – for example, critical thinking and problem solving skills. The literature review demonstrated that student nurses experience
fear and anxiety in the clinical setting. The important gap in the literature is that no studies recognize the issue of how to help student nurses face fear in interacting with patients as a priority in nursing education. The data from this study suggest that the fear of interacting with patients was a concern of the participants new to the clinical setting. Several participants discussed the importance of the nursing instructor in helping with specific fears, particularly for reassurance that the participant was performing a skill correctly or interacting with a patient appropriately. Most of the nursing literature does not guide nurse educators on how to assist students with fear and anxiety that occur in a learning environment with patients. A study by Becker and Neuwirth (2002), however, found a creative way to help students with anxiety. When senior nursing students performed as teaching assistants with junior nursing students new to clinical experiences, the junior students reported a decrease in anxiety. The decrease in anxiety was due to having another knowledgeable person (besides the instructor and the RN) in the clinical setting to ask for help.

Fear is a noun that expresses emotion. Fear is defined as “an emotion of alarm or agitation caused by the expectation or realization of danger; a state or condition marked by this feeling” (American Heritage Dictionary, 1985, p. 493). The participants used various synonyms of fear to describe how it felt to be in nurse/patient interactions. These synonyms included the words afraid, anxious, nervous, scared, intimidated, frightened, worried, concerned, and timid. All of these words describe similar feelings of a state or condition of being. One of the research questions of this study was, “How do student nurses describe being in
their nurse/patient interactions?" One answer is that students describe feeling fear – to be a student nurse is to experience being as fearful. As participants reflected back upon nurse/patient interactions, they described the process or activity of existing (i.e., being) as fear of interacting with patients.

In his classic book, *The Courage to Be*, Tillich (1952) distinguished between fear and anxiety in a way that fits the experiences of these participants. According to Tillich, fear is usually directed toward an object, whereas anxiety is usually a sense of no direction, or lack of an object upon which to focus. Fear is being afraid of something that is not necessarily an object, but is the “anxiety about the possible implications” (p. 37). The participants in this study described specific fears such as fear of talking to the patient and saying the wrong thing, fear of hurting the patient, and fear of performing skills.

Clearly, if someone can articulate a specific fear, coping mechanisms can be identified to assist an individual to overcome the fear. If a student nurse expresses fear of hurting a patient before giving an injection, then discussing the steps with the instructor before giving the injection would help the student focus on an object of fear. This review of steps allows the student nurse to identify a specific plan to decrease her fear, in this example her fear of hurting the patient, and to increase courage. This student/instructor interaction models how the student nurse will think for herself in facing an object of fear in the future.

Courage is the way to meet every object of fear (Tillich, 1952).

In contrast, if a person experiences anxiety, a specific object of concern is difficult to identify. In anxiety, the threat is the concern itself, or fear of the
unknown (Tillich, 1952). Anxiety is defined as a state of uneasiness and distress about future uncertainties (American Heritage Dictionary, 1985). Student nurses are new to interacting with patients, and may not be able to articulate specific objects of concern. Participants in this study expressed anxiety before walking into patient rooms, knowing the roles of a student nurse, and interacting with patients. In order to assist a student nurse who is experiencing anxiety, a nurse educator could talk individually with that student to explore the student’s feelings. Finding specific areas where anxiety is felt or experienced may allow for identification of specific objects of concern. Once an object of anxiety is identified, coping mechanisms can also be identified. Tillich stated the importance of defining anxiety:

Anxiety is the painful feeling of not being able to deal with the threat of a special situation. But a more exact analysis shows that in the anxiety about any special situation, anxiety about the human situation as such is implied. It is the anxiety of not being able to preserve one's own being which underlies every fear and is the frightening element in the situation. (p. 38)

The understanding of the difference between fear and anxiety becomes key to nursing education. It is important for a nursing faculty member to assist a student nurse to distinguish between a specific fear and anxiety. If a student can articulate a certain fear, then the instructor and student can discuss strategies to alleviate that fear. If the student states she is anxious, continuing to experience nurse/patient interactions may allow for specific fears to be identified and confronted. If anxiety is simply fear of the unknown – how it is to be a student nurse – then experiencing nurse/patient interactions with the instructor in the interaction may assist the student to develop courage. Reflecting back on the
interactions after experiencing a fear or anxiety allows the student nurse to know being fearful or anxious in a given nurse/patient interaction. Learning occurs through reflecting back on a lived experience (Peters, 2000; Schoen, 1983; Taylor, 2004). By reflecting back on an interaction, a student nurse finds how it was for her to live the experience of fear or anxiety and learn how she did or did not successfully cope with these emotions.

*Developing confidence.* The theme of developing confidence was a thread through almost every participant’s experiences. As discussed in chapter four, confidence was achieved from a successful skill implementation, from using a successful skill implementation to increase confidence in a patient interaction, and from an increase in confidence from a single patient interaction. Many of the participants identified experience as the way to develop confidence. Repeatedly in the journal submissions, the end of a submission included a sentence or two regarding how the described experience had helped the participant develop confidence. The participants found meaning in successful outcomes in patient interactions as developing confidence. Patient support, instructor support, increased knowledge from the classroom, and especially repeat experiences in interacting with patients were identified by the participants as factors that helped in developing more confidence.

The participants in this study identified the importance of the nursing instructor as a factor in developing confidence. The nurse educator is the teacher of the student in the clinical setting and in the classroom, and is a role model in nursing practice. The nurse educator verifies a nursing skill performed correctly
or verifies knowledge applied correctly through interactions with student nurses. A study by Haffer and Raingruber (1998) found that support from instructors, patients, and self are the best ways to develop confidence. These researchers concluded that nursing instructors should create safe places for students who are developing confidence in nurse/patient interactions. If a student is not comfortable with the nursing instructor, and perhaps even fearful of the instructor, developing confidence is hindered. Nurse educators must understand the importance of their roles in student nurses’ abilities to develop confidence.

_Becoming self-aware._ The third theme, becoming self-aware, is similar to the theme of developing confidence, yet different. The similarity is the focus on the individual in an experience, and the reflection of the individual that allows for learning to occur. The difference is what the reflection uncovers - developing confidence comes from affirmation and finding meaning in a successful outcome; becoming self-aware comes from finding some aspect of self, some meaning to the student nurse’s experience from _being_ a nurse. To illustrate how student nurses begin to experience nursing, Haffer and Raingruber (1998) wrote,

> When students first enter the practice of nursing, they must learn different habits, new traditions, new patterns of relating, and new skills. Part of how students learn to understand what it means to be a nurse is through interactions with others within the world of nursing. As students start acquiring a personal view of the nursing world, they try out new behaviors and ways of viewing themselves. (pp. 67-68)

Through the clinical setting, student nurses begin to experience nursing in interactions with patients. Student nurses become aware of themselves as nurses through these interactions. Reflecting back upon experiences through journal
writing is an excellent method for student nurses to become aware of meaning and of *being* as a nurse.

Journal writing is identified as one method for making meaning of a clinical experience (Callister, 1993). Callister described a clinical learning journal as a written record that reflects the student nurse’s attitudes, feelings, and expansion of his or her cognitive learning. Journal writing allows the active and integrated learning between theory, research, and clinical experiences to come alive for student nurses. Reflection, defined by Taylor (2004), is a means of “throwing back thoughts and memories, in cognitive acts such as thinking, contemplation, meditation, and any other form of attentive consideration, in order to makes sense of them” (p. 28). Reflective thought involves experiencing (i.e., *being*), interpreting (i.e., meaning), and therefore learning from an interaction.

The theme of becoming self-aware can be tied integrally to theories of student development. Student nurses develop during the college years into whom they are becoming as adults. Becoming self-aware connects how students develop cognitively and psychologically into adults. Theories of student development conceptually define a college education as involving the whole person and as a process involving an interaction between developing intellectual and interpersonal competence (Brown & Gillis, 1999). Several theories of student development connect to the theme of becoming self aware. Nursing faculty can apply student development concepts to assist student nurses as they develop as nurses and individuals.
One student development theorist, Chickering (1969), determined that becoming self-aware or establishing identity is a learned mastery over time in college. The art and science intertwined in a nurse/patient relationship is a learned mastery as well. The theme of becoming self-aware connects with Chickering’s vector (or concept) of establishing inner identity. As nurse educators, awareness of student nurses establishing their inner identity as individuals and as nurses is powerful. Student nurses are searching for identity to self as a person and to self as a nurse. Perhaps in interactions with students, nursing instructors should be aware of teaching more than just nursing content or skills. Nursing instructors could embrace the roles of listening to students and reflecting one-on-one with a student nurse who is questioning identity as a nurse or adult, to help her or him with identity integration. Opportunities to address self-awareness in reflective papers or small group discussions would further allow for identity recognition and integration.

Belenky, Clinchy, Goldberger, and Tarule (1986) studied the development of women as college students and wrote about it in their book *Women’s Ways of Knowing*. The findings of Belenky et al. led to increased understanding of how women grow into adulthood during the college years, and suggest a connection to the theme of becoming self-aware from this study. One relevant concept from *Women's Ways of Knowing* is subjective knowers/procedural knowers. Subjective knowers are women who look to their inner voice for the first time and start trusting self; procedural knowers pay attention to objects in the world with their feet planted firmly having learned about self. The journals in the study
presented here suggest participants were finding and developing their voices and inner selves as individuals and as nurses. An implication for nurse educators is to be open to assisting students to hear and be aware of their inner voices. The outcome of helping students trust their inner selves will support the emerging identities of the student nurses.

A cognitive theorist, Marcia Baxter Magolda (1992), studied traditional college students across four years of baccalaureate education in a Midwestern university. In her research, Baxter Magolda looked at how men and women develop in self-awareness through patterns of knowing and named the theory the Epistemological Reflection Model. The premise of Baxter Magolda’s patterns of knowing is the importance of the meaning of a learning experience, which occurs from interaction with others and from the learner’s view of his/her world. The journals from this study suggest a relationship to the transitional pattern of knowing, where knowledge becomes uncertain. The data from this study suggest that nursing instructors need to recognize a student who is transitioning from a certainty or truth, to a questioning of those inner truths. Nurse educators can serve as supporters and active listeners in the student’s search for self awareness.

Nurse educators need to understand the importance of the development of self that occurs within a student nurse. The literature review described the importance of teaching the science of nursing. Obviously, a nursing program must achieve outcomes related to knowledge acquisition of nursing. However, the theme of becoming self aware supports the importance of the overall development of self awareness as a nurse. Many nurse educators have little
understanding of student development theory; however, nurse educators must assist student nurses to develop fully as nurses. The theorists described above -- Chickering, Baxter Magolda, and Belenky et al. -- describe how development occurs over time. Realizing the college years are not just a time for learning knowledge but also a time for self development is key for nurse educators to understand.

Nurse educators can assist student nurses in becoming self aware by first seeing when these situations of self awareness are occurring. Baxter Magolda (1992) discussed the importance of allowing time for reflection on experiences as college students transition to transitional knowing. Belenky et al.(1986) discussed how moving from subjective to procedural knowing is demonstrated by moving from inner reflection toward a more active voice with authority figures or with peers. Applying concepts from these theories is important to the theme of becoming self aware.

Students who are becoming self aware need support to know that developing self awareness as a nurse and as an adult is normal. Ways for nursing instructors to support self awareness is to allow time for reflection. One of the key concepts of this research was being. First described by Heidegger (1927/1962), being can only be described as a “relatedness backward,” where we study the looking back at a process rather than study an object (Heidegger, 1962/1999, p. 277). To understand being, then, is to look backward at an experience or situation after it has occurred and to focus on the process that occurred. Nursing instructors
must be cognizant of the importance of allowing time for student nurses to reflect back upon experiences to fully experience the process of becoming self aware.

Nursing instructors can provide time to reflect upon experiences in post conferences after clinical experiences, through paperwork assignments from clinical experiences, through journal writing, and through personal interactions. Post conferences are frequently structured experiences at the end of a clinical day. A creative way for allowing time for self awareness is to have a discussion group online. The safety of writing experiences in a discussion group may allow for more openness than a face-to-face discussion for some students. Writing through paperwork assignments or journals allows another venue for student time for reflection of experiences. Encouraging personal interactions with the instructor, peers, nurses, or self is another way for becoming self aware.

*Connecting with knowledge.* Research is profuse in the nursing literature describing the knowledge connection, or science of nursing education. The literature concerning the science of nursing describes problem-solved learning, content learning and skill acquisition, and ways to improve and measure critical thinking (see chapter two). The participants in this study suggested, through the theme connecting with knowledge, how knowledge from the classroom or skills acquired are experienced in patient interactions. Theories of cognitive development fit well in supporting the theme of connecting to knowledge, as do theories of learning. Theorists who defined how college students develop cognitive skills are Perry (1970) and Kolb (1984). Learning theorists who help inform the findings in this study include Gagne (1977) and Bandura (1986).
Connecting with knowledge, as defined by the participants, demonstrates the science of nursing – the content, skills, and knowledge of nursing practice (Donahue, 1985; O’Brien, 2001) discussed in chapter two.

Perry’s (1970) theory identified stages, or “positions” of intellectual and ethical development in college students. Perry’s dualistic and multiplistic positions suggest a fit to the student who was described earlier in the chapter as being “hit on” by her patient. Dualistic thinkers see a situation as having either a right or wrong answer; multiplistic thinkers see a situation as having multiple answers that could be correct. The participant described earlier in this chapter was reflecting back and trying to decide what she really felt from the interaction.

Kolb’s (1984) theory of learning styles in college students also connects to the participants in this study. The key concept of Kolb’s theory is that knowledge is created through a reflective learning process. Kolb posits that learning occurs through increasing complexity and relativism in interacting with experiences in the social and educational environments. The participants in this study each described unique ways of learning in various situations. The implications for nursing educators are to be aware that nursing students learn differently, in different situations. Students need to be encouraged to express what helps them learn best in a given situation.

Gagne’, Bandura, and Vygotsky are learning theorists whose work can inform the theme of connecting with knowledge. Gagne’ (1986) identified five varieties of learning categories – verbal information, intellectual skills, cognitive strategies, motor skills, and attitudes. Categories of learning are important for
nursing faculty to understand in helping student nurses learn in both the classroom and the clinical setting. Bandura (1986) identified the importance of modeled behavior in his theory of social-cognitive learning. Bandura’s theory suggests the learning, modeling, and performance of competencies of nursing technical skills – giving injections, starting IV’s, doing dressing changes - are socially learned from modeling. Vygotsky (1927/1997) developed a cultural-historical learning theory of psychological development from a constructivism perspective. Participants learned how to experience being nurses – the caring, reflective practice of the art of nursing and the critical thinking and skill acquisition of the science of nursing – through nurse/patient interactions. Vygotsky’s theory is an appropriate framework for understanding how these participants learned to construct the art and science of nursing in their experiences with patients. The theories of Gagne’, Bandura, and Vygotsky provide frameworks which lend support to the theme of connecting with knowledge.

Connecting with patients. Connecting with patients, the fifth theme, is the heart of nursing. Connecting with patients means listening, touching, communicating, understanding, caring – so many words that describe a special human relationship known as the nurse/patient interaction. The heart of nursing exists in the interaction of a nurse with a patient. To connect in the midst of the interaction is the art of nursing. Chinn (1994) stated the “art of nursing is the art/act of the experience-in-the-moment” (p. 24). The experience-in-the-moment, the art of nursing must be lived in nurse/patient interactions. Participants in this study repeatedly discussed how important clinical experiences were to learning
how to be a nurse. A quote that summarizes connecting with patients in clinical also summarizes the being of a nursing student:

Overall, I now realize that clinical is what you make it to be. It is a learning experience which you can greatly benefit from only if you make the most of it, looking for every opportunity or chance to practice skills, assess patients, overlook doctors or other nurses and even following patients throughout the hospital to any tests or appointments they may have. It is a time for me to be independent, embrace my fears and keep the patient’s health and well-being as my number one priority while learning and growing as a future nurse.

Summary of implications. The above implications suggest nurse educators must understand the student nurse perspective as opposed to focusing on the nurse educator perspective. The significance of the participants’ voices cannot be emphasized too strongly. The richness of the data and the analysis of findings uncovered led to the implications. The participants shared a depth of emotion through the journals that deeply touched me. The participants also shared in the journals a true desire to learn and the desire to become good nurses. The participants’ reflections demonstrated learning the being of nursing through nurse/patient interactions as well as through reflecting upon the interactions.

The theme of connecting with knowledge and the review of literature in chapter two suggest the great importance of learning the science of nursing. The data support how connecting with knowledge occurred for these participants. Application of various learning theories supports how student nurses connect with the art and science of nursing. In comparison, student development theories discussed previously suggest the process of learning in how student nurses develop as nurses and adults. While all these theories are important, the key is how an individual student learns to experience nursing. Students need to be
encouraged to express what helps them learn best in a given situation. Nurse educators need to understand that student nurses are not passive learners but active learners. Each student constructs knowledge of nursing for him/herself through personal experiences and through different ways of thinking or experiencing nursing. Varied clinical experiences, computer simulations, classroom teaching strategies, and interactions with patients will best allow for connecting with knowledge.

The participants’ reflections call forth the *being* in nursing. The lived experiences of these participants who were new to nurse/patient interactions shine a different perspective on *being* in nursing. Through the eyes of someone new to an experience (these first semester nursing students), the experience is seen differently than from the perspective of someone familiar with similar experiences (experienced nurse educators). Nurse educators are expert nurses. Seeing nurse/patient interactions through the eyes of these participants creates a new perspective. The participants connected with nursing knowledge, patients, and themselves through these experiences.

Connections with knowledge and connections with patients are where the art and science of nursing are learned by nursing students. These connections occur during clinical experiences. Nurse educators must understand the importance of clinical experiences for nursing students in learning how to experience nursing. Nurse educators can have a significant impact upon the learning of the student nurse. Palmer (1993) called teachers the mediators between the learner and the subject to be learned, stating:
The teacher, not some theory, is the living link in the epistemological chain. The way a teacher plays the mediator role conveys both an epistemology and an ethic to the student, both an approach to knowing and an approach to living. I teach more than a body of knowledge or a set of skills. I teach a mode of relationship between the knower and the known, a way of being in the world. (pp. 29-30)

To fully understand the experiences of a student nurse is to begin to become a better teacher of nursing. I must enter the world of the student nurses to be able to help them begin to understand the being of nursing. Understanding student nurse perspectives of learning should change the lens of thought of the nursing instructor.

The sharing of knowledge from this research through presentations and article submissions is key to assisting faculty to be better teachers. Nurse educators are frequently experts in practice, but novices in nurse education. Student development theories and learning theories provide structure to understanding how students think and learn. Student development theories focus on the process of learning and developing; learning theories focus on the how of learning. Nursing instructors need to know these theories to understand fully how best to assist nursing students to learn as nurses and develop as individuals.

Conclusions

The purpose of this dissertation was to understand how student nurses learn to experience being and presence in nursing. The research with 28 sophomore nursing students across a semester of their clinical experiences uncovered five themes of being and presence. These themes – fear of interacting with patients, developing confidence, becoming self-aware, connecting with
knowledge, and connecting with patients - come together to define the lived experiences of these student nurses as they learned in the clinical setting.

The first chapter of this dissertation defined elements of nursing - science, art, caring, presence, *being*, the art and science of nursing, nurse/patient interaction, and sacred space. All these elements intertwine with the themes to define how student nurses experience *being* and presence in nurse/patient interactions. The themes and elements combine to make sense, or meaning, of how student nurses experience *being* in nursing. As a result, four major conclusions can be drawn from this study.

The first conclusion is that clinical experiences provide excellent opportunities for students to learn the art and science of nursing. This conclusion could apply to many faculty in any chosen college major. In this study, the clinical experiences provided for student nurse interactions with patients. Student nurses experienced *being*, presence, and meaning by intertwining the art and science of nursing in nurse/patient interactions. The participants did not experience either “art” or “science,” but rather intertwined both together. The art and science of nursing were intertwined in the experiences of the participants, and therefore in the themes uncovered from analysis of the experiences.

Nurse/patient interactions provide opportunities for learning as the participants reflect back upon the *being* and meaning in clinical situations. Participants in this research identified important connections between the art and science of nursing as they experienced *being* in nurse/patient interactions. Participants could articulate specific knowledge or science from the classroom
that was applicable to patient care in the clinical setting. The interactions with patients allowed participants to experience nursing, which is the application of the science of nursing and the true art of care while present to a patient.

The importance of nurse/patient interactions for student nurses’ learning is clear. The participants in this research repeatedly illustrated the importance of experience in the clinical setting to learning how to be a nurse. One participant stated, “The more interactions I had, the more I felt comfortable about myself. So, nursing experience really helped me grow my nursing skills, especially my interaction skills.” All the themes uncovered in this study evolved from nurse/patients interactions – the clinical experiences. Fears were identified, confidence was developed, and the participants became self aware through interactions with patients. Participants wanted to be in clinical to learn how to experience nursing. Being, meaning, and presence are lived through interactions with patients. Experiences with patients provide the best learning opportunities for becoming a nurse (Doane, 2002; Patterson & Zderad, 1976). Nurses intertwine the art and science of nursing in interactions with patients.

The second conclusion is that nursing education must be restructured to include a balance of the art and science of nursing. If student nurses clearly learn from intertwining the art and science of nursing, then curricular structure must parallel how student nurses learn. Traditionally, nursing curricula focus solely on science courses as prerequisites to nursing coursework, as well as have a heavy science focus. Using behavioral objectives to measure outcomes of the educational process again demonstrates the focus on science (Bevis & Watson,
Clearly, the science of nursing is very important to the curricula of nursing programs. The resulting education of student nurses is therefore an “applied” science, borrowing from medicine, biological, and physical sciences. Doane (2002) noted that science is a technical *doing* of nursing and nurses should open up to feeling and the *being* of nursing. The curricular structure of nursing education *must* include the arts and humanities to educate a nurse who balances the art and science of nursing.

Because nursing is a humanistic profession, the strong science focus of prerequisite nursing education must shift to include a balance with the arts. Paterson and Zderad (1976) noted that: “Science may provide the nurse with knowledge on which to base her (his) decision, but it remains for the arts and humanities to direct the nurse toward examination of value underlying her practice” (p. 87). Perhaps a shift from science courses to arts and humanities courses as prerequisites in the general education curricula of a nursing major would open the door to other perspectives. Watson (2001a) stated that nursing is a balance of masculine and feminine. The science of objective knowledge is the masculine; the feeling and sacred caring is the feminine. Chinn (1998) created an introduction to the art of nursing course. I recommend that every nursing program curricula should incorporate, at the least, a class presentation, or preferably an elective course, focused on the art of nursing.

The third conclusion is that reflection or journal writing is a valuable way to enhance learning. A faculty member in any college course could enhance learning through inclusion of reflection or journaling. Reflecting back through
journal writing allows for the understanding of the experience. Learning occurs from reflection. To enhance how student nurses learn, particularly through the intertwining of the art and science of nursing, reflection must be a part of nursing education. Journal writing should be implemented following clinical experiences, including open-ended suggestions for student nurses to guide the learning process.

The final conclusion is that student nurses are developing identity simultaneously as a nurse and as a person. Student nurses are college students. This simple statement means that two different kinds of learning are occurring – learning nursing and learning about self. The participants in this study were developing an identity to self as a person and to self as a nurse. Nursing faculty must never lose sight that to teach student nurses is not just to guide a student nurse’s knowledge development of nursing, but to guide a student nurse’s development into adulthood. Nursing faculty assist student nurses to learn nursing, but must also be aware of the overall student identity development.

College students are in a unique environment for developing psychosocially, intellectually, spiritually, mentally, and personally. The undergraduate years of a traditional college student are when individuals separate from the parental values and beliefs learned as children and integrate experiences to develop self identity. The development of identity of a college student is affected by many varied interactions and experiences. Every faculty member in a college or university should be aware that both in-classroom and out-of-classroom experiences impact a student’s individual development.
Limitations

Several limitations existed in the study design. First, the demographics of the participants are unknown. In the original proposal, a questionnaire was designed to elicit information concerning gender, age, previous nursing experiences, ethnicity, years of college, and out-of-classroom experiences. The system used of obtaining consent signatures with the demographic fact sheet proved to be inefficient. Presenting the explanation of the research in a classroom of 50 students, repeated over three separate sessions, was too chaotic to be sure the coding system stayed intact. Future studies should include an organized system where each consent signature page has a code number and a corresponding demographic sheet code, as well as consistency in obtaining demographic data. Not knowing age, experience, ethnicity, and other demographic data limits the ability to interpret the findings. The demographic data would give depth to this study.

A second limitation was the reliance on one method of data collection. Multiple methods provide richness of data as well as trustworthiness of data. For example, my witnessing the participant give the 300 pound Navy veteran an injection, may have validated the participant’s conclusion about the patient’s fear of needles. Including the classroom or post-conference discussions would provide another venue of student sharing that would enhance the richness of the data. Interviews with the participants after a patient interaction would provide another means of data collection. The researcher could have interviewed the participants after their interactions with patients. All these examples of data
collection would have provided triangulation of the data and added to its trustworthiness.

A third limitation was the inability to always ascertain the answer to the research question “How do student nurses experience the various levels of presence in nurse patient interactions?” I relied upon the participants’ words to describe presence with patients, which at times did not provide enough information to ascertain the level of presence the student nurse and patient were experiencing. The definition of presence in chapters one and two included four levels of presence as identified by Osterman and Schwartz-Barcott (1996). In future research, the inclusion of multiple methods would allow for recognition of the level of presence.

The fourth and final limitation was the lack of the use of the classroom or learning laboratory as other sites of data collection. The classroom and nursing learning laboratory are important learning sites in nursing education. Participant observation in either or both of these sites would provide an alternative method to enrich the data collection in the study. Using the themes from this study as a priori themes in future research and incorporating the above limitations might support and further develop the data uncovered in this study.

Future Research

Through a new lens of seeing, I envision a wealth of ideas for future research. A longitudinal study of student nurses across the four years of the college experience might fully uncover how student nurses experience being and presence. The five themes found in this study would be further illustrated with
more lived experiences of increasing numbers of student nurses across time of the educational process. The themes from this research could become a priori categories of a future research project. I also believe the theme of sacred space should be explored through longitudinal study of individual student nurses. A longitudinal study might uncover college student development issues, particularly the development of identity as individuals and as nurses. This longitudinal study would cover the time frame of nursing experiences prior to the Benner (1984) Theory of Novice to Expert in Nursing, which identifies development of expertise in nursing practice from graduation (novice) to expert practitioner.

Qualitative research is not generalizable and a recommendation would be to repeat this research in other groups of nursing students at the same university. Every year another group of students is admitted to the sophomore year. The course structure, the instructors, and especially the different students would create new experiences. Another recommendation would be to repeat this research at other four-year colleges and universities to investigate if these findings exist in other contexts.

Another recommendation is to conduct research with nursing students relating to cognitive student development and theories of learning. These student nurses are also college students, and psychosocial and cognitive development theories should be explored specifically with them. Theories of learning could also be explored with nursing student learning. Little research in learning theory or student development theory has been investigated specifically with nursing students. Due to the unique learning of nursing as an art and a science, detailed
knowledge of how nursing students think and develop would further assist
nursing educators in designing curricula with student nurses. An awareness of
how student nurses develop identity into adulthood and as nurses would be
another area of research that would add to the knowledge of nursing education.

Future research should investigate the use of reflective journaling to assist
student nurses to understand the art and science of nursing as they care for
patients in the clinical setting. Reflection was discussed in previous chapters for
the importance of self awareness and learning in practice. Creative nurse
educators could study the use of reflective writing or journaling in a multitude of
ways in various clinical settings across a curriculum of a nursing program to
optimize learning. For example, students could journal after hearing a lecture to
reflect on the content just taught in the classroom. Journaling could be useful in
learning nursing and in student development in general.

A recommendation for higher education in general is applicable. Every
major of a college or university should assess for some balance to the curricula.
A major in science, for example engineering, should include some arts and
humanities in its curricula. In contrast, a major in art should incorporate some
science coursework into its curricula. A balance between art and science allows
for development of a well-rounded individual and provides opportunities for
college students to interact with students of other viewpoints and ways of
thinking.
Final Thoughts

The student nurse learns the art and science of nursing through nurse/patient interactions, but the nursing instructor is the guide to assist in the learning. The importance of faculty who understand how student nurses learn the art and science of nursing, and understand student development in general, is key to student learning. Faculty who clearly subscribe to incorporating both art and science in nursing practice should be the instructors of new nurses. Nurse faculty who are experts in theory development, nursing science focused, or research focused may be best equipped to teach primarily at the graduate level for two reasons. First, a shortage of nursing faculty educated at the doctoral level exists, so the PhD or DNS faculty member has to teach at the graduate level to meet the needs of nursing education (Hall, 2004). Second, these nursing faculty (experts in theory, nursing science focused, or research focused) may not be as astute about the intertwining of the art and science of nursing as an nurse actively in practice.

Gendron (1994) identified the intertwining of the art and science of nursing as creating a tapestry. The warp of a tapestry is the bare strings set in a loom. In nursing, the warp is the science – the foundation of knowledge in nursing care. The weft in a tapestry is the threads in the loom that are woven across the warp strings to create an individual image. The weft in nursing is the art – the authentic interaction of a nurse and a patient. The weaving of a tapestry is therefore very much like a nurse/patient interaction, according to Gendron (1994). What a beautiful analogy to teach a student nurse about a nurse/patient interaction.
As a nurse of 27 years, I apply Gendron’s analogy of nursing to nursing education. I can clearly understand the art and science of nursing from the perspective of an expert nurse educator, as I watch a student nurse weave a tapestry with a patient. Eisner (1998) discussed an expert’s understanding in a concept he names “educational connoisseurship.” The “ability to make fine-grained discriminations among complex and subtle qualities” (p. 63) is how Eisner defined connoisseurship. In valuing the art of nursing, I become a connoisseur of the differentiations as students discover and begin to live experiences of nursing.

Eisner (1998) identified the theory-practice relationship in any art form. Eisner stated that labels and theories provide a way of seeing but also a way of not seeing. By this statement, Eisner is suggesting that one must move beyond cognitive knowledge, to disregard what one knows. If an individual focuses on what is seen, or known, perception is limited to what can be labeled or fit into a theory or concept. Moving to what cannot be labeled or seen, is moving beyond what is known. The ability to move beyond what is known is to move from doing to being. Eisner defines the processes of connoisseurship as examples of epistemic seeing. Epistemic seeing was first coined by Dretske (1969) and was defined as knowledge obtained through sight. Watson (2001a) states the nursing profession needs “a new lens for seeing” (p. 47). I challenge nurse educators to see through a new lens - seeing through the eyes of student nurses.

As I reflect back on this entire dissertation, the “seeing” is clear. I now also clearly see the faculty viewpoint in nursing education. Three ways of being
exist in nursing education – the *being* of nurse/patient interactions; the *being* of pedagogy; and the *being* of self. First, a nurse readily returns to *being* a nurse – he or she is the person who is always there with the patient – the *being* of nurse/patient interactions. Nurses are the individuals who hold hands; are patient advocates; are in unique interactions with patients in ways that no other health care professionals experience. Second, nursing educators are the individuals who teach new students of nursing - the *being* of pedagogy. The *being* of pedagogy is where learning occurs for new students of nursing and the profession of nursing is further researched and defined. Third, the nurse is an individual person embodied in this world –the *being* of self. An individual is composed of a mind/body/spirit that makes a person the individual God created and who he/she becomes as life is experienced. Nurse educators as individuals need to embrace the unique qualities of *being* that only nurse educators can experience in their lives.

O’Brien (2001) so clearly sees the uniqueness of nursing in her description of caring for frail elderly residents in a nursing facility.

I spent many hours visiting with the residents. Almost invariably the elders would reach out and take my hand during a visit; sometimes they would hold it up to their faces, as my mother used to do when I was a child. With the decrease in functional abilities, both physical and cognitive, a heightened sensitivity to touching and to being touched often develops. Elders recognize the brevity of life and are willing to live and to love in the moment. They have time to touch and to be touched, to be totally present to one another. Elders know they must not live in the future, for the future is now. This is an important lesson for all of us. I developed treasured relationships with these frail elders and experienced the healing power of both giving and receiving loving touch on many occasions. (p. 46)

To be a nurse is to touch life physically, emotionally, intellectually, and spiritually. To teach students the art and science of nursing is an honor and a joy.
May anyone who experiences the joys of teaching nursing students share the beauty of nursing. May the art and science of nursing be the blessing to others that it has been and continues to be for me.
Chapter 6
Personal Journal

All these things I probed in wisdom. I said “I will acquire wisdom” but it was beyond me. What exists is far reaching; it is deep, very deep; who can find it out? (New American Bible, Ecclesiastes 7:23-24)

In this chapter, I will reflect on my being. I had many days, hours, and minutes of personal reflection during the two years of writing my dissertation. In one of these many moments, a dear friend, Sister Breta (personal communication, October 13, 2004) spoke these profound words - “Step back and gaze.” A Sister of Mercy, Sister Breta has walked the paths with Mary (a dear friend now in Heaven) and me as we journeyed toward a PhD in Higher Education. As I take Sister Breta’s words to heart – to “step back and gaze” – I can see clearly what these two years of research have taught me.

As I gaze at nursing education, I gain knowledge from my seeing. I see that being in clinical practice with a nursing instructor is where the student nurse experiences being. The key to learning how to experience being for that student is then to reflect back upon the experience through journaling. The meaning uncovered will assist the student to grow into the art and science of nursing practice. Trying to fit individual student interactions into concepts or a theory detracts from the experience of being where the student learns nursing. The touch, care, skills, experience-in-the-moment, presence, and sacredness of the nurse/patient interaction cannot be taught but must be experienced. Nursing
students must experience nurse/patient interactions to see, to be in the art and science of nursing.

From a higher education perspective, the mission, philosophy, and curriculum of a school of nursing must match the education that occurs in the institution. If a university or college subscribes to a strong science philosophy, the faculty is likely to base a curricular structure on a behavioral objective, a scientific approach. If the institution is a liberal arts college, perhaps the intertwining of art and science is more a fit with the curricular structure. Faculty in any school of nursing must first agree upon the mission and philosophy of the school and of nursing in order for the curricula of the nursing program to flow logically. The faculty must come to consensus of how the curriculum is designed in order for students to understand nursing.

The concept of intertwining the art and science in nursing education returns the profession full circle to the historical beginning of nursing with Florence Nightingale. Discussed in chapter two, it was Nightingale who first saw nursing as a profession, and used a light to illuminate patient care, both literally and symbolically. One of Nightingale’s important contributions to nursing was her *Letters to Nurses* – reflections on her beliefs about nursing. Nightingale (1915) first defined the art and science of nursing practice and education.

A final conclusion of this dissertation must include the lived experience of the researcher. I first met with my dissertation advisor on December 20, 2002. I knew I wanted to research how student nurses learn in the clinical setting – but on this day that was merely a topic to explore. Through weekly meetings with my
advisor, I was pushed and encouraged to continue to “dig deeper.” I experienced many days of deepness – discovering a depth of emotion and feeling within me that I had never been aware existed.

The most significant outcome of these two years has been connectedness. I experienced many times the being of life. At times, words or thoughts came to me as I drove a car; as I cleaned the house; through words in a book or a journal article; as I found places to sit and reflect, usually with my cat Mindy (aka The Roosk); as I prayed a rosary; as I was in a sleep/wake state, or through dreams remembered upon waking. I journaled throughout the two years to stay in touch with my experiences, and at times sought personal counseling to find deeper answers. I poured out heartfelt words and emotion to my husband, my friends, and my God. Through all of these experiences, I connected with what it meant to be me. I connected with the person in me who is so present to everyone else; who wears her heart on her sleeve; who is known as the positive person who is always passionate and encouraging to others. I connected with self and became that person I had always been to everyone else but myself. I finally embraced all the life I have lived and all the people who have connected to me.

From the connections, I discovered being Sue. I no longer live into the future, but am very aware of my life within every hour of every day. I live the moment – I look into a student’s eyes and really listen when he or she talks to me. I actively listen and reflect back to other faculty what they are saying to me. I touch or hold the elderly residents in my arms when I work in the Sacred Heart Home. I give myself to my husband in sharing our precious days together. I
cherish time with my father, brother, and nephew and feel blessed to have moments with everyone special to me every day of my life. I most importantly share moments with my God – in my morning Rosary and in my ways of living life.

From the self connection, I have learned the importance of acceptance of self in order to connect to others. I remember myself as a young student nurse in the 1970s who had little connection to self. Although my connection to self has been very deep and powerful through this dissertation, I also know my self connection has created a better nurse and educator of college students. I am aware my journey is not a journey anyone else would experience the same way or to the same depth.

I do believe that student nurses must affirm themselves as individuals in order to be good nurses who can connect to their patients. I believe this self connection is a work in process throughout life and student nurses must be made aware of this fact to begin the connecting to self. O’Donohue (1997) wrote in his book *Anam Cara* (Celtic for soul friend):

There is such an intimate connection between the way we look at things and what we actually discover. If you can learn to look at yourself and your life in a gentle, creative, and adventurous way, you will be eternally surprised at what you find. We see everything through the lens of thought. Each of us needs to learn the unique language of our own soul. In that distinctive language, we will discover a lens of thought to brighten and illuminate our inner world. Dostoyevsky said that many peoples lived their lives without ever finding themselves in themselves. It is a great point of growth in your life when you allow what is luminous within to awaken you. This may be the first time you actually see yourself as you are. This process of self-discovery is not easy; it may involve suffering, doubt, dismay. But we must not shrink from the fullness of our being in attempting to reduce the pain. (p. 33)
Through this dissertation I looked inside myself and realized the importance of connecting to self. The participants in this study began to connect to themselves through their lived experiences as nursing students. I suggest that student nurses should be affirmed for the experiences that awaken self - to illuminate the soul. Chinn (2001) suggested the holistic, healing art of nursing is comparable to any art form, which is an activity that forms elements into a whole. Student nurses become whole when they touch their souls. Becoming self-aware is to touch your own soul. What better learning in an educational experience than to touch your soul and befriend yourself. I not only have touched my soul, but I embrace my self and all who touch my life.

I close with a blessing from John O’Donohue (1999), from his book *Eternal Echoes* (p. 50):

Blessed be the longing that brought you here and that quickens your soul with wonder.
May you have the courage to befriend your eternal longing.
May you enjoy the critical and creative companionship of the question “Who am I?” and may it brighten your longing.
May a secret Providence guide your thought and shelter your feeling.
May your mind inhabit your life with the same sureness with which your body belongs to the world.
May the sense of something absent enlarge your life.
May your soul be as free as the ever-new waves of the sea.
May you succumb to the danger of growth.
May you live in the neighbourhood of wonder.
May you belong to love with the wildness of Dance.
May you know that you are ever embraced in the kind circle of God.
Amen.
References


Appendix A

Questionnaire for Participants

Code number

Age               Gender

Years of college completed?

Do you currently work?  What type of work do you do?

Describe the following if you have any experiences to report – (use as much room as you need; if no experiences, just say none.)

Significant past experiences in nurse/patient interactions where you were the nursing student:

Significant past experiences with family in nurse/patient interactions:

Significant past experiences in nurse/patient interactions where you were the patient:

Describe your college experience at this institution – participation in sports, organizations, attending events, living arrangements (dorm, apartment, other)

Address/contact info to send you results of the study and for possible follow-up:
Appendix B

Consent for Participation

Title: Nursing Students’ Experiences of Being: A Hermeneutic Approach  
Principle Investigator: Sue Ideczak, MSN, RN, CNS  
Contact Phone Number: 419-383-5855  24 Hour Pager Number: 419-620-5444  
Electronic Mail address: Mstudy@mco.edu  
Study Advisor: Penny Poplin Gosetti  Contact Number: 419-530-5570  
Human Subjects Rights at The University of Toledo: 419-530-1231

PURPOSE: You have been asked to participate in this study because you are a nursing student in the first year of clinical nursing courses. The purpose of this study is to investigate how student nurses experience nurse/patient interactions. The potential outcome of this study is to assist nursing faculty to optimize student nurse learning in the clinical setting.

PROCEDURE: After a clinical experience, you would have the opportunity to answer six open-ended questions. You would be asked to record your answers in one of three manners: 1. in paper and pencil written form; 2. in an electronic document sent on a computer by electronic mail either in text or in document form attached to email; or 3. typed and printed on paper. No information identifying you will stay with the recorded answers. Your name and the names of anyone else mentioned will be replaced by a pseudonym. I will be visiting weekly alternating between your class or clinical to see you, and to obtain any hand written or typed reflections. I will also be available by electronic mail or by pager for any questions you may have. You will be given a copy of the results after the study is completed if you would like them. The amount of time needed to participate will depend upon the frequency and the depth of the reflective responses.

If you choose to participate in this study you may (a) submit a journal entry after each clinical experience or (b) submit journal entries at times of your choosing. Ideally, you will answer the six questions after each clinical experience; however, I would value as many responses as you are able to provide over the course of the semester.

RISKS: You may feel emotions that are uncomfortable in reliving the experiences of any sensitive topics. If you should feel the need to talk to someone about your feelings or experiences, I will refer you to an appropriate professional. Your participation in this study will not affect your clinical nor your classroom coursework at the University of Michigan.
BENEFITS: The benefits of your participation may include that reflecting upon your clinical experiences may be enlightening and allow you to learn about yourself. You may also experience some satisfaction from participating in the study knowing you helping nursing instructors to be more aware of how student nurses make meaning of nurse/patient interactions and to design coursework and assessment that may be more effective.

CONFIDENTIALITY: Your records will be available only to me and my dissertation advisor. The advisor will never see the names of the participants. The confidentiality of your records will be maintained by me. Written records will be stored in a locked cabinet in my home; consent forms, which by necessity include names, will be kept in a different location in my home.

VOLUNTARY PARTICIPATION: Your decision to participate or not in this study will not affect your status as a student nor affect your grade in this course at the University of Michigan. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time. You are free to withhold any information you prefer not to record from your clinical experiences. You may stop participating at any time and, if you stop, you may start participating again at any time.

NEW INFORMATION: You will be provided with any new information developed during the course of research that may relate to your willingness to continue or discontinue participation in this study.

AGREEMENT: Your signature indicates that you have read the information provided above and that you agree to participate.

____________________________
Signature of Participant

____________________________
Signature of Witness

____________________________
Date
Appendix C

Script for Initial Meeting with Participants

Thank you for allowing me to meet with you. My name is Sue Idczak, and I am a nursing professor at the Medical College of Ohio in Toledo, Ohio. I am also a graduate student at the University of Toledo. My major is Higher Education and I am researching my dissertation. I am here to talk to you to explain my research and to ask you to be participants in the research.

I have explained my research with Mrs. Fashbinder and your other clinical instructors. I have also been given permission by the Health Human Subjects Research Board to be meeting with and working with all of you.

My research is looking at how you experience interacting with patients. Nursing is an art and a science. Florence Nightingale and many other nurses have defined nursing as an art and a science. I have learned through my review of all the nursing literature that nursing instructors teach the science of nursing well – the knowledge of what to do for a patient with diarrhea, or with a patient having difficulty breathing, is science. The skills of dressing changes, starting IV’s, putting in catheters are also science. The art of nursing is the experience of caring for the patient, or in interacting with the patient. How students learn the science of nursing – the skills and knowledge – is researched and understood by nurse educators. How students learn the art of nursing is not researched and understood. How you – a student nurse - experience being with a patient – interacting with a patient as a nursing student - that is what I want you to tell me about in my research.

What you would have to do is to answer six questions after a clinical experience – every other week when you are in clinical or as many times as you choose. Even answering the questions one time would be just fine. The six questions you would answer are the same each time. The questions are:

1. Describe an interaction you had with a patient today.
2. What were your thoughts or emotions while you were in the interaction.
3. Describe how you felt about yourself during the interaction.
4. Describe how you felt about the patient during the interaction.
5. What did I not ask you that you would like to tell me?
6. Any other thoughts or feeling you want to share?

You can email me the answers to these questions; type the answers and print them, or hand write the answers on paper or a journal. You will have a specific email address to send the answers if you choose to email. I will
come once a week to see you, just to be with you and to pick up any papers in person.

The most important point to tell you is your participation in my research is completely voluntary. Your coursework here at U of M is not affected either by your decision to participate or not participate in my research. All of you are invited to participate. You also need to know your answers will be treated confidentially. Your names will never appear with what you wrote – I will have you choose a code number and I will remove any distinguishing features of you or your patient – gender, race, disease process of your patients. Only the stories will speak of your experiences. Two brief examples – J.H. (ER sacred space story) and C. Y. (fingerstick story). Stories are powerful and your stories will help nursing educators understand how students learn to interact with patients. Think of the Chicken Soup for the Soup books – how people’s stories make such an impact. I hope to publish the summaries of your stories in a nursing journal someday.

I am giving you a copy of the consent you will need to sign to participate in my research. Please take it home, read it, and email me, call me, or page me with any questions. I will return a week from today to again answer any questions and to have you give me your signed consent to participate. You will also have a brief questionnaire to fill out at that time – the code number you will be choosing, some brief descriptive information about you.

Please do not hesitate to ask me questions. Does anyone have any questions? IF you think of any questions or comments, email me, call me, or page me.

I am so honored to meet with you and to have U of M nursing students to work with these four months. Thank you for you time.