University of Alberta

The Process of Senior Nursing Student-Patient Connection: Student and Clinical Nursing Faculty Perceptions

by

Hazel Kathleen Ruth White-Williams

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Faculty of Nursing

Fall 2012
Edmonton, Alberta

The process of senior nursing student-patient connection: Student and clinical nursing faculty perceptions

Abstract

Background: With the current national shortage of nurses, technical aspects of nursing practice are emphasized, often to the detriment of relational aspects of patient engagement. A major concern in undergraduate nursing education today is how to help nursing students develop their skills and abilities to fully engage with their patients. There is little or no evidence about this process in the literature, specifically about how nursing students connect with their patients.

Purpose: The purpose of this study was to examine the process of connecting in the student-patient relationship from both the student and clinical nursing faculty perceptions. The following research questions guided this study:

1. How do senior nursing students describe their connection with patients?
    a. What is/are the process(es) of connection in the senior nursing student-patient relationship?
    b. What factors influence the process of connection?
2. How do clinical nursing faculty describe senior nursing student-patient connection?
    a. What are the dimensions of this connection?
    b. What factors influence the connection?

Design: A Glaserian grounded theory approach was used with individual student semi-structured interviews and one focus group session with clinical nursing faculty. All interviews and the focus group session took place in a designated area in the Faculty of Nursing.

Sample: Purposive and theoretical sampling was used to recruit 4th year undergraduate nursing students who were enrolled in a 4th year medical-surgical clinical nursing course. The students practiced in acute adult medical-surgical settings. The students understood and spoke English, and were able and willing to reflect upon and articulate their experiences. The clinical nursing faculty were recruited from those currently teaching a 4th year medical-surgical clinical nursing course at the time of the study.

Data Collection & Analysis: In accordance with the grounded theory approach, data collection and analysis occurred simultaneously. The 'constant comparative analysis' technique was used.

Results: I developed a theory grounded in data about the process of connection within the senior nursing student-patient relationship. This research adds depth of knowledge to our understanding and is valuable in informing nursing education and continuing competence processes in nursing practice.

Keywords: nursing student-patient relationship, connection, mutuality, Glaserian grounded theory, nursing education, medical-surgical nursing.

ACKNOWLEDGMENTS

This was an incredible journey. As life events unfolded, I found new meaning in the words determination, courage and resilience. I am very grateful to the people who encouraged me to continue and who contributed to the successful completion of this academic pursuit. To my advisors, Dr. Beverly Williams and Dr. Rene Day, I would like to convey my sincere appreciation for your encouragement and continued support throughout this doctoral experience. Under your mentorship and coaching, I saw the way forward in a richer, more sophisticated and complex way of learning and being.

I wish to thank my dissertation committee members Dr. Pauline Paul, Dr. Florence Myrick, Dr. Joanne Olson, Dr. Joanne Profetto-McGrath, Dr. Carol Jillings, and Dr. Marie Cave for their support, guidance, and critique to enhance my study. A special thanks to Dr. Joanne Olson who, in the middle of an environmental interruption, chaired this committee with diligence and grace.

To the baccalaureate nursing students, and the clinical nursing faculty who so generously gave of their time to participate in this study, I want to express my deepest thanks. It was an honor to share in your experiences.

A special thanks to my colleagues, in particular, Soo, Rosalina, Jane, Nancy and Margaret for your kindness, generosity, encouragement and friendship. To Kathleen, Cindy, Jason and Lenore, I extend my sincere appreciation for your on-going support during my studies.

I wish to acknowledge my family who never gave up hope that this dream of mine would come true. I owe a tremendous debt of gratitude to my husband

Gerry who travelled this journey with me and who shared in the sacrifices, celebrations, and uncertainties, and to Shawn and Joanne, Scott and Aisha, and Stephanie who reminded me often about the importance of balance and family. Finally, to my father, mom and grandchildren, thank you for your unconditional love.

TABLE OF CONTENTS

APPENDICES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Healthcare reform and organizational remodelling strongly influence how nurses provide nursing care in hospitals. Efficient and effective economic outcomes and streamlined healthcare delivery models are the focus within the healthcare environment (Ramey & Bunkers, 2006). Technical competency seems to be valued by health care administrators, while less value and emphasis is placed on relational competency. Relational competency is a critical component of ethical nursing practice. It is important for nurses to "come to know patients for whom they are, what their present health situation means to them, and what they desire for quality of life" (Ramey & Bunkers, 2006, p. 311). Research suggests that patients also identify the nurse-patient relationship as an essential element of quality nursing care (Irurita, 1999; Thorsteinsson, 2002).

The Research Problem

According to the Canadian Code of Ethics for Registered Nurses, the nurse-patient relationship is foundational to ethical practice (CNA, 2008). Nurses have a responsibility to understand and care about others' health care needs. In order to accomplish this nurses consciously build trustworthy relationships with their patients. It is through committing to consciously engaging in meaningful communication that nurses build these trustworthy relationships. Such relationships are critical to understanding the needs and concerns of patients and are the focus of nursing education in the classroom. Practicing nurses are role

models for students learning about the meaningful communication in the nurse patient relationship within the clinical setting.

A key component in the initial phase of the nurse-patient relationship is being able to make and sustain a positive connection with the patient. According to the Merriam-Webster dictionary (2009), the etymology of the word 'connection' comes from the Latin words 'connexion', and 'conectere'. The Latin word 'conectere' translates into connect, an intransitive verb, meaning "to bind", "to become joined", "to have or establish a rapport". 'Connect', a transitive verb, means "to place or establish in relationship". Nurses initiate, maintain and terminate relationships with patients. A positive connection, in the initial phase of the therapeutic relationship, develops with each encounter, and has the potential to improve the efficacy of the therapeutic relationship (Heifner, 1993).

To develop a therapeutic nursing student-patient relationship, and appreciate its significance as a major emphasis in the gestalt of nursing, nursing students need opportunities to establish meaningful connection with patients, to understand what this experience means for the patient, agree on appropriate courses of action, skillfully carry out nursing activities, and act ethically (Johnson, 1994). Newman (2002) describes a progression of nursing knowledge that she refers to as holarchical, meaning that each level of knowledge development is whole within itself and that each succeeding level "transcends and includes" the previous level, thus creating a larger whole. She emphasizes a need for nurses to move away from a focus mainly on physical care to a focus that also includes

emphasis on the interpersonal process. Such an integrative approach has a greater potential to enhance nursing practice and patient outcomes.

The current hospital milieu has been described as reflecting an objective, factual and value-free ideal (Georges & McGuire, 2004), which might mean that observations are impartial, there is a reliance on facts, and that the patients' values are not considered as much as they could be. This modernistic view has been described as autocratic, militaristic and paternalistic (Cody, 2000). Hospital decision-makers might therefore seem to value cost containment, and tend to minimize the notion of human condition and suffering. It is possible that nurses perpetuate this notion by valuing efficient system planning initiatives such as clinical care pathways. Clinical care pathways are described as a corporate style approach with the aim of efficiency, quality and a conduit for evidence informed theory (George & McGuire, 2004). This type of decision-making, while efficient, can potentially overshadow educational opportunities for nurses to mentor nursing students to engage in ethical practice. Some nurses may feel duty-bound to carry out the task related activities of nursing care prescribed within the care pathway. They may feel they do not have time to engage with students and mentor them in developing confidence, competence, and capacity in individualized patient care and therapeutic student-patient relationship (Chinn, 2001, p. v; Turkel & Ray, 2012).

The current context of the clinical practice setting could potentially limit student engagement with patients. Further, the embodiment of being a nurse is disrupted when the emphasis is placed on the person as a physical being rather

than the person as a wholistic being (Picard, 1997). This experience is reflective of Newman's description of the physical care that nurses focused on in the 1970s. It seems that today there is still a disconnect between the education received, the practice witnessed, and the experiences of nursing students in the hospital clinical practice setting. Moscaritolo (2009) describes this as a 'theory gap', meaning "there is a discrepancy between what is taught in the classroom and what is practiced in the clinical setting" (p. 17). In my role as educator, I am often asked by students why they need all this education when they say that all they are doing in their medical-surgical placement is changing dressings, passing medications, and following the plan of care or clinical care pathway. Students comment on experiencing more support for their learning needs and social relational support in intensive care unit placements, but find it difficult to establish relationships on the medical-surgical units (Hartigan-Rogers, Cobbett, Amirault & Muise-Davis, 2007). Nursing students also commented that the priorities of qualified nurses seem to be paperwork, tasks and routines, at the expense of communication with patients (Pearcey & Draper, 2008). I believe that the student-patient relationship, specifically connecting with patients in the initial phase of the development of the relationship, and continuing to build on this connection throughout the relationship, might be key to students learning how to interact in a positive way with their patients. This has the potential to influence therapeutic outcomes for patients. It could have the potential to influence student satisfaction with their clinical learning experience.

Little research has explored nursing student-patient relationships from the point of view of nursing students. As this knowledge could contribute to better teaching and learning opportunities for students to develop a therapeutic relationship with patients, and could potentially improve quality of care for patients, this phenomenon warrants further study. Qualitative approaches acknowledge the importance of context and allow the nursing students' and patients' values and perspectives to be heard directly. Hence, qualitative approaches, such as the grounded theory method proposed for this study, can provide rich, dense data, understanding, and ultimately a substantive theory grounded in the data. This theory could effectively inform nursing curricula revision, and continuing education for nursing faculty and registered nurses.

In summary, there is a need to examine the nursing student-patient connection and the process(es) inherent in the trajectory of this phenomenon. To date, both qualitative and quantitative approaches, using a variety of phenomena, have been used to study nursing students generally. I plan to explore the process of senior nursing student-patient connection using the qualitative approach of Glaserian grounded theory as method.

Purpose of the Study

The purpose of this study is to examine the process of connecting in the student-patient relationship from both the student and clinical nursing faculty perspectives.

Research Questions

The following research questions guided this study:

How did senior nursing students describe their connection with patients?

a. What is/are the process(es) of connection in the senior nursing student-patient relationship?
b. What factors influence the process of connection?

How do clinical nursing faculty describe senior student-patient connection?

a. What are the dimensions of this connection?
b. What factors influence the connection?

Significance of the Study

The fundamental basis for focusing nursing research on the development of nursing knowledge in the area of the student-patient relationship comes from the articulation of the renewed focus for the nursing discipline, on the therapeutic nurse-patient relationship. I believe the student-patient relationship, specifically connecting patients in the initial phase of the relationship, and building on this connection, might be a key factor in students' learning and potentially a factor that influences therapeutic outcomes for patients (Ironside, Diekelmann & Hirschmann, 2005a).

The present state of knowledge regarding connection was determined by exploring literature from the disciplines of nursing, education, sociology, psychology and medicine. Suikkala and Leino-Kilpi (2001) completed a

substantive literature review (1984-1998). The following criteria were used to select relevant literature: must address the student-patient or patient-student relationship, be peer reviewed, and be published after 1998. There is a plethora of literature related to the study of nursing students. There is less literature that specifically examines the phenomenon of student-patient relationship in various contexts, and no literature was found that studied the process of student-patient connection as a distinct part of the relationship.

This study has the potential to add to the development of nursing knowledge, theory and practice related to the development of therapeutic relationships in professional nursing practice. Making a positive connection may be the first important step in developing effective therapeutic relationships with patients. Patients who experience a strong connection with a nurse are likely to engage more fully with decisions regarding their plan of care (Bryant, 2009; Heifner, 1993; Nix & Dillon, 1986). Knowing more about connection and the factors that affect it might assist academic and health care institutions to better understand how to facilitate student learning about the concept and help clinical faculty nurture it as the initial phase in developing a therapeutic relationship. Perhaps educators would then be able to incorporate the theory of connection into curriculum planning. An understanding of the importance of connection in the nurse-patient relationship could strengthen the practice of nursing students and ultimately registered nurses.

My Assumptions

I have observed that students interact differently with each patient and that patients also respond differently to various students. Some students are readily able to develop meaningful relationships with their patients while others struggle to do so. For example, in helping patients to manage their pain, some students actively listen to what the patient tells them about what has worked before while other students simply prepare and administer the medication as prescribed without exploring conditions that may be associated with the pain. These differences are even more apparent in the current practice milieu. It is likely that there are a variety of influences on how students are socialized into nursing. It is likely that the socialization of students into nursing is affected by the current health care environment, the quality of role-modelling they observe and the individual personal characteristics of both practicing nurses and patients (Pearcey & Draper, 2008). Recent healthcare restructuring and economic restraint have created hospital environments that tend to emphasize the technical aspects of nursing care in the interests of efficiency (Turkel & Ray, 2010). This environment could also be limiting nurses' ability to role model the true 'gestalt' of nursing which involves incorporating the relational aspects with the technical aspects of nursing care. Nursing students are socialized and engage in behaviours role-modelled by practicing nurses during their practicum experiences. Some students question the notion of only attending to the "task" or technical aspect of giving care while other students are content to follow the status quo. During clinical practica, the students who follow the status quo, tend to emphasize psychomotor skills while

those who seem to connect with their patients are also concerned with the patient experience.

Summary

I have discussed the research problem, the purpose of the study, the research questions, the significance of the study, and my assumptions as the researcher. In the next chapter, I will discuss the present state of knowledge as revealed in the literature.

CHAPTER II

PRESENT STATE OF KNOWLEDGE

> "…they (nurses) report systematic demands that value their medical skills but that prevent them from engaging in meaningful interactions with patients and clients, detract them from learning the actual situation from which someone enters the medical care system, and inhibit their abilities to reach out to provide meaningful, let alone comprehensive, nursing care" (Chinn, 2001, p. v).

Restructuring in the health care environment has encouraged practices that have affected the nature of an effective nurse-patient relationship. For example, shortened length of stay, standardized care, documentation, and technology create an environment that fosters reduced proximity to the patient, and limited time to 'hear' the specific meaning of what this illness/event holds for the patient (Evans, 2007). The 'heart' of nursing is the therapeutic nurse-patient relationship. Moreover, developing the knowledge, skills and judgment required to engage in a therapeutic student – patient relationship and negotiate care (Gordon, Ellis-Hill & Ashburn, 2009) is pivotal to how the student will enact this relationship as a registered nurse.

Newman, Smith, Pharris and Jones (2008), in revisiting the focus for the discipline of nursing, claim that the nurse-patient relationship is what unites the practice of nursing on a daily basis, in many locations throughout the world. Since the initial teaching/learning about the therapeutic relationship begins in undergraduate nursing education, students learn about, and teach others the 'ought-to-be' nursing practice. I support Ferrari's (2006), claim that the role of academics is to understand the factors that influence the nurse-patient relationship in the experiences of nursing students. Knowledge of these factors, such as

facilitated reflection, could inform best practices, curriculum change, and ultimately quality client care.

Grounded theory is useful for the discovery of concepts and propositions. Therefore, this present state of knowledge is not an in-depth review of literature nor is it a critique of the literature in any depth at this time. Addressing the student-patient relationship literature was to determine: 1) if this relationship and connection within this relationship has been studied, 2) what methodology and design were used, 3) the findings, and 4) to determine no replication of a study has been completed. In doing so, I was less tempted to contaminate, hinder, stifle, or be constrained by my efforts to generate categories, their properties, and theoretical codes from data, thus assuring the data fit, are relevant and work (Glaser, 1992). I analyzed and critiqued the literature in more depth as the theory emerged.

The present state of knowledge regarding connection in the nursing student-patient relationship was determined by exploring literature from the disciplines of nursing, education, sociology, psychology and medicine. The following criteria were used to select relevant literature: must address the student – patient or patient-student relationship, be peer reviewed, and published within the last 12 years. While there is a wealth of literature related to the study of nursing students, there is less literature that specifically examines the phenomenon of student – patient relationships in various contexts (Suikkala, Leino-Kilpi & Karajisto, 2008 a&b). Literature that examines the phenomenon of connection as part of the student-patient relationship is scant, and no literature

was found that reported studies about the process of students connecting with patients in the relationship.

My discussion of the literature represents nine major components and their relevant substantive theoretical and empirical contributions toward the present state of knowledge regarding therapeutic relationships and connection within the relationship. These components include: definitions, professional guidelines and standards, the health care environment, educational preparation of nurses, nursing theory/practice, nurse-patient relationships, staff nurse-student relationships, faculty-student relationships, and nurse student-patient relationships.

Definitions

According to the Merriam-Webster dictionary (2009), the word 'relationship' means "the relation connecting or binding participants in a relationship" and "a state of affairs existing between those having relations or dealings". Arnold and Boggs (2007) define a therapeutic relationship as "a professional alliance in which the nurse and client join together for a defined period of time to achieve health related treatment goals" (p. 92). The Registered Nurses' Association of Ontario (2006) defines a therapeutic relationship as "grounded in an interpersonal process that occurs between the nurse and the client(s). Therapeutic relationship is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome for the client" (p. 13). A key component in the initial phase of the nurse-patient relationship is the ability of the nurse to make and sustain a positive connection with the patient (Heifner, 1993). According to the Merriam-Webster dictionary (2009), the etymology of the word

‘connection’ comes from the Latin words ‘connexion’ and ‘conectere’. The Latin word ‘conectere’ translates into ‘connect’, an intransitive verb, meaning “to bind”, “to become joined”, “to have or establish a rapport”. ‘Connect’, a transitive verb, means “to place or establish in relationship”. There is scant literature related to the definition of connection within a relationship. Nix and Dillon (1986) defined connectedness as “the identification by the patient of the nurse as a reliable resource” (p. 495). Heifner (1993) identified the theory of “mutual connectedness” highlighting that the patient-nurse interaction is based on knowing one another, nurse care and patient trust. Heifner later identified essential elements of nurse-patient connectedness. Both of these studies were conducted in psychiatric settings with nurses and patients. These studies will be discussed later in this chapter.

Professional Guidelines, Standards, and Competencies

Professional nursing associations at both the provincial and national levels have developed principles and values that nurses can use to guide their practice. For example, the College of Nurses’ of Ontario, 2006 and 2008, the Registered Nurses’ Association of Ontario, 2006, and the Canadian Nurses Association, 2008. Most guidelines include aspects related to establishing therapeutic relationships and engaging in patient/client centered care. Professional association guidelines tend to describe the therapeutic relationship as an interpersonal process that occurs between the nurse and the patient. The therapeutic relationship provides a purpose and goal that focuses on enhancing the best outcome for the client. It is clear that nurses require a high level of self-awareness, and nursing

knowledge from a variety of sources including research, theories, experience, patients, peers, and self-reflection to holistically engage in client centered care. It is recommended that professional nursing association guidelines and entry-level registered nurse competencies be used as a basis for identifying content and outcomes when planning core nursing education curricula. Most guidelines are informed by the theoretical work of such scholars as Peplau (1952), Tudor (1952), Orlando (1961), and Forchuck (1995).

The Health Care Environment

Perhaps one of the most critical theoretical basis of concern for our knowledge development is associated with the unique needs of the patient (Kim, 2000). The conceptual basis of nursing has emerged over time. During the period of 1950-1960, the focus of nursing was on "doing for" the patient (McEwen & Wills, 2007) which has been linked with the medical model of care. Gradually there was a shift to emphasizing the importance of interacting with the patient which reflected a social/interactive approach to care. Currently the emphasis seems to be on interacting with the patient as a wholistic being (Newman, Smith, Pharris & Jones, 2008). However, the trajectory of the discipline is probably more ideal than real as we still hear concerns from both patients and nurses about patients "being done to". Many leaders in the health care environment seem to view the patient as a consumer of health care, that is, someone who is buying a product such as an echocardiogram. In the current environment of fiscal restraint, many factors influence the management of hospital health care spending: economic uncertainty, development of health care indicators, length of stay for

specific procedures, shortage of health care personnel especially nurses, competing research agendas, and programs competing for sparse funding (Georges & McGuire, 2004). Nursing's opportunity to engage in therapeutic nurse-patient relationship is in direct competition with the direction of the health care agenda. In addition, agents external to nursing are implementing systems to collect data to ultimately ensure effective and efficient revenue flow while containing costs. These processes often create additional work for already busy nurses. An example is the Health Outcomes for Better Information and Care Project being introduced in Ontario hospitals and nursing homes over the next few years (Ministry of Health & Long-term Care, 2007). This is a provincial government initiative, with nursing leadership, aimed at capturing quantitative data regarding a patient's daily activities, but it does not include any mention of the psychosocial aspects of patient care. Over the next few years, data will capture the physical nature, or presentable aspect, of the patient experience (Ministry of Health & Long Term Care, 2007).

Some nurses tend to think that the system priorities will interfere with the mandate of nursing to serve the patient. It is possible that once again, nursing as we know it may become less important in the health care environment. Will task oriented activities become the focus for nursing care, and the experience of the patient become less important? Given that this is the environment that students will join when they graduate, it is essential that an emphasis is placed on the importance of the nurse-patient relationship in their undergraduate nursing education. Students need to understand how this relationship is pivotal to their

ability to create meaningful connections with patients and potentially facilitate a quality health outcome for the patient.

Educational Preparation of Nurses

The educational preparation of all nursing students, and in particular undergraduate students, needs to be grounded in the current focus of the discipline as defined by the concepts of health, caring, consciousness, mutual process, patterning, presence, and meaning (Newman et al, 2008; Willis, Grace &, Roy, 2008). Nurses embody these concepts by engaging in authentic nurse-patient relationships. The teacher's scholarship needs to reflect these same views in order to articulate and facilitate the 'unitary-transformative' paradigm of the discipline of nursing (Newman, Sime & Corcoran-Perry, 1991; Watson & Smith, 2002), and concurrently, include pertinent knowledge from other disciplines such as education and psychology in order to keep current with the needs of society.

Ferrari (2006) explored how nursing students understood the role that education played in helping them comprehend factors that could impact the relationship between nurses and patients. Using an exploratory qualitative design, unstructured interviews and the learning techniques of reflection and self-awareness with four pre-registration nursing students, Ferrari found that academic education played a key role in promoting an understanding of the nurse-patient relationship. Knowledge regarding student-patient relationships, particularly related to connection (Ironside, Diekelmann & Hirschmann, 2005b) in the undergraduate curriculum could ultimately have a major impact on nursing

practice and patient care. Nursing graduates need to have knowledge grounded in the discipline of nursing in order to sustain and grow as professionals in nursing.

Theory/Nursing Theory/Practice

Nursing draws on knowledge from different disciplines to enhance the substantive knowledge for the discipline and practice of nursing (McEwen & Willis, 2007; Meleis, 2007). A number of theories that are relevant to the development of the nurse-patient relationship, and that could provide the theoretical base for student-patient relationships, will be highlighted.

Sullivan's interpersonal theory influenced nursing theorists in the mid to latter half of the 20th century (McEwen & Wills, 2007). His premise for developing a theory was that a person must be engaged with other people in order to exist (Sullivan, 1953). Peplau (1963) asserted that if nurses wanted to be effective, they needed to be part of, and not isolated from (role of participant-observer), the therapeutic milieu. Peplau also believed that the nurse draws on the values of respect, empathy and acceptance when interacting with the patient as a human being. She described the nurse-patient relationship as an interaction between participants, each bringing their own unique contributions. This combination or 'coming together' in a caring, sharing way (therapeutic way) is more important than the individual contribution of either nurse or patient (Gastmans, 1998; Peplau, 1992; Peplau, 1994; Rask & Brunt, 2007). Barker and Buchanan-Barker (2005), referring to patients' 'life journeys' state "that effective nursing rests on the assumption that a caring relationship involves *caring with people* rather than simply caring *for* them or caring *about* them" (p. 23).

Rogers (1959) introduced the concept of person-centered care, emphasizing an equal partnership between the nurse and the client. His major contribution to nursing practice is the understanding that each patient/client is a unique individual, who is basically good, with an inherent potential for self-actualization (McEwen & Wills, 2007; Rogers, 1959). In addition, Rogers identified the conditions necessary for an authentic therapeutic relationship and these included unconditional positive regard, empathetic understanding, and genuineness. Orlando's theory (1961) focuses mainly on client participation, which draws a parallel with both Sullivan's and Peplau's concept of participant-observer. To form, develop, use and terminate a nurse-patient (client) relationship, is an event that is critical to study in nursing since this relationship underpins any therapeutic interaction and effective treatment outcome (Forchuck, Westwell, Martin, Bamber-Azzaparedi, Kosterewa-Tolman & Hux, 2000).

Many other nursing theorists contributed models and theories that could provide a theoretical base for nursing student-patient relationships. A brief précis, by category, is provided here. A number of them developed theories focusing on 'nursing clients', for example, Johnson (1980), Roy (1991) and Neuman (1982, 1995). The core of their theories was to provide a framework to understand who the patient is (Meleis, 2007). The questions that these theories generated concentrated on the processes of stability and instability, adaptation, and coping. In addition, they explored the outcomes of nurses' interventions that facilitate and promote these processes (Meleis, 2007).

Other nurse theorists focused on nursing as a ‘process of interaction’. King (1987), Orlando (1961), Paterson and Zderad (1976, 1988), Travelbee (1966, 1971), and Wiedenbach and Falls (1978) provided the groundwork for studying such processes as relationships between nurses and patients, and the organization and structure of interpersonal relationships (Meleis, 2007). Many of the concepts found in these theories are part of our lexicon today, for example, lived experiences, interaction, trust building, and advocacy.

The fundamental basis for focusing nursing research on the development of nursing knowledge in the area of the student-patient relationship comes from the articulation of the renewed focus on the nursing discipline, which is the therapeutic nurse-patient relationship (Newman, Smith, Pharris & Jones, 2008). It is likely the student – patient relationship and connecting within this relationship is key to students’ learning, to providing quality nursing care, and to promoting therapeutic outcomes for the patients.

Nurse-Patient Relationship

Shattell (2004) conducted a literature review on nurse-patient interaction using an unspecified number of articles and did not identify a timeframe. The findings indicated that power, the social and cultural context, and interpersonal competence in the quality of nurse-patient interactions were important. Shattell identified four important perspectives: 1) nurse communication within nurse-patient interactions, 2) nurse-patient interaction in the context of life-threatening or terminal illness, 3) patient perception of nurse-patient interaction, and 4) patient care-seeking communication.

The first perspective was nurse communication within nurse-patient interactions. Shattell concluded that most of the studies did not consider the patient perspective, and focused mainly on the 'power' position of the nurse in an encounter. Further findings indicated that patients acquiesced to the nurses' agenda in order to not be labelled as a 'bad' or 'difficult'. Moreover, they maintained a positive outlook to enact the façade of an 'easy' patient (Hewston, 1995; Johnson & Webb, 1995). A key discussion point from this study was that nursing students did not improve communication skills, despite further education and practice. It seems that greater prior nursing related experience the students acquired, the less desirable their communication patterns (Harrison, Pistolessi & Stephen, 1989). This might suggest that students have learned good communication skills in their prior work- related experience. However, the findings in this review indicate that they did not integrate these behaviours in socially acceptable patterns of communication. For example, they used pressure to gain the patient's cooperation. Furthermore, nursing students wanted to care for patients who could talk with them, who were cheerful, and who acknowledged their illness and were willing to allow the nurse to do care for them. It is likely that effective communication skills are central to initiating and maintaining a therapeutic nurse-patient relationship.

According to Shattell, the second perspective was nurse-patient interaction in the context of life-threatening or terminal illness. An interesting finding here was that patients viewed the nurse-patient interaction as therapeutic (Altschul, 1971). Moreover, patients were able to speak about certain nurses who they felt

helped them during their hospital stay. The patients identified certain characteristics that they wanted nurses to possess: to be genuine, to have time for the patient, and to freely engage in conversation. The findings indicated that the nurses were skeptical about the value of their relationship, and these same nurses apparently scorned other nurses who claimed to have a therapeutic relationship with their patients.

The third perspective was patient perception of nurse-patient interaction. Interestingly, Shattell reported that only three studies explored this concept. Fosbinder (1994) conducted a qualitative ethnographic study with patients (n=40) and nurses (n=12) from orthopedic and cardiac units of a private hospital to seek the patients' perceptions of nurse-patient interactions. A theory of interpersonal competence emerged from data in this study. Findings indicate that patients talked 'overwhelmingly' about the interpersonal interaction. Four themes emerged from the data: 1) translating, such as instructing and teaching, 2) getting to know you, such as personal sharing, 3) establishing trust, such as being prompt, and 4) going the extra mile, such as being a friend. It is likely that the patients' contribution to the study of nurse-patient interaction is important and warrants further study. A phenomenological study conducted by Drew (1986) found that the patient's experience with caregivers was both exclusionary and confirmatory. Exclusionary experience was interpreted to mean that the patients felt excluded, that their feelings were disregarded, and they felt like they were drained of energy. Confirmatory experience was interpreted to be energy giving. These findings are consistent with Shattell (2004) who found that hospital environments were

disconnected and disconfirming places for patients. Breeze and Repper (1998) conducted an ethnographic study of mental health patients who were labeled as 'difficult', using focus groups with nurses (n= 9) and unstructured interviews with patients (n=6), to determine patients' perceptions of care experiences. The data from the interviews were analyzed using a stage-by-stage approach adopted from grounded theory. Three themes emerged from the data: control, patient response, and nurse intervention. Patients responded to their lack of control and perception of being forced into conforming with interventions with negative behavior and anger to 'struggle to control' their environment. The findings indicate that the patients wanted to be listened to and respected.

The last perspective identified by Shattell was patient care-seeking communication. Few studies have been conducted on patients as active participants in the nurse-patient interaction. Most research in this area was conducted by Russell (1994, 1996) and Pettegrew and Turkat (1986). In Pettegrew and Turkat's study, two instruments (Patient Communicator Style Measure and Illness Behaviour Inventory) were used with 50 patients (response rate 52%) to examine how patients communicated with their providers and what the influence of that communication had on the patient-provider relationship. A positive correlation was found between social illness behavior (frequently talking about one's illness, acting sicker than one feels) and assertive communication styles (dramatic, contentious, animated) and increased visits for health care (Pettegrew & Turkat).

Shattell's review has increased our knowledge regarding the communication behaviours of patients, nurses and nursing students in a nurse-patient interaction. Shattell's review provides a great deal of information about nurses' communication patterns with patients, and indicates that very little is known about the patients' contribution to the nurse-patient interaction. Increased communication skills education and nursing related experience did not foster positive communication behaviours of nursing students (Shattell). It is likely that quality of care was decreased for patients whose nurses had labeled them 'difficult' or 'bad'. Contrary to popular thought, nurse-patient interactions can be accomplished in a relatively short period of time. Patients felt that this interaction was more important than other aspects of care, and further identified important characteristics they would like to see nurses display: genuineness, respectfulness, valuing patients, and willing to take time to talk (Shattell). Further, findings from this review tend to have many implications for nursing practice, in particular, the importance of the nurse-patient relationship and the concept of connecting during interaction with patients.

More recently, Rask and Brunt (2007) offered a conceptual model that describes the therapeutic nurse-patient interaction in forensic psychiatric care and labelled the model verbal and social interaction. Six categories of nurse-patient interaction were identified: building and sustaining relationships, supportive/encouraging interactions, social skills training, reality orientation, and practical skills training (p. 169). The model depicts how these categories of interaction are linked which are well described in the literature. Using grounded

theory, Scanlon (2006) conducted a study to ascertain the nature and comprehension psychiatric nurses assigned to the development of a therapeutic relationship. Scanlon found that the relationship was therapeutic, but difficult to measure. Scanlon also reported that the importance of having the lived experience (learning) to acquire interpersonal skills and appreciate the value of the therapeutic nature of relationships was dependent on the nurse having sufficient life experience to appreciate the therapeutic features of the relationship. de Raeve (2002b) examined the concepts of trust and trustworthiness from the perspective of the patient's trust in the nurse. She found that for nurses to respond in a trustworthy manner, they must care *about*, and not just *for*, the patient . In addition, de Raeve (2002a) in a related study of emotional responses determined that different criteria are needed to assess the authenticity of the nurse-patient relationship. According to Naef (2006), bearing witness to another's experience, a moral way of engaging in nurse-person relationship, does require a significant and substantive knowledge base that values that being present with another is a necessary aspect of nursing practice. Coffey (2006) explored the concept of nurse-patient covenant using concept analysis to consider how nurses and patients form relationships in cancer care. She defined this concept in cancer care as "an enduring relationship, embodying caring benevolence and contextually negotiated reciprocity" (p. 308).

Gordon, Ellis-Hill and Ashburn (2009) conducted an observational study (n=14 nursing staff and n= 5 patients with aphasia or dysarthria) utilizing videotape and field notes, and content analysis. Findings from this study indicated

that nurses controlled the topic and flow of conversations by using short, closed questions creating asymmetrical interactions between nurse and patient. This finding seems contradictory to the goals of rehabilitation, which are focused on patient goals, anxiety, and future plans. Perhaps the nurses in this context felt uncomfortable or had difficulty with patients who could not verbalize their needs. A theory grounded in data about the process(es) of a establishing a therapeutic nurse-patient relationship, in particular, how to connect with patients, might be beneficial in this rehabilitation context.

Evans (2007) explored the concept of transference from psychoanalytic theory as posited by Lucan and Freud in the nurse-patient relationship in a psychiatric context. The development of a "psychical holding" emerged allowing for communication between the nurse and patient in ways that the patient could not speak about to his/her family or friends.

The only study that focused on connectedness was Nix and Dillon (1986). They developed a short-term nursing therapy conceptual model for inpatient psychiatric care. As part of this model, they defined connectedness as the "identification by the patient of the nurse as a reliable resource" (p. 495). It is likely nurses on in-patient units have to quickly establish connectedness in order to begin the patient treatment program. Schubert (1989) and Heifner (1993) focused on the patient's perception of the therapeutic interaction process. The theory of "mutual connectedness" was identified, that is to say, the patient-nurse interaction is based on knowing one another, nurse care and patient trust. Based on these findings, Heifner studied psychiatric nurses' perception of connectedness

in the therapeutic nurse patient relationship. Specifically, an exploratory, descriptive qualitative design was utilized to explore how nurses experienced a positive connection and what facilitated and contributed to establishing connectedness. Many themes emerged from the data: vulnerability, commonalities, reciprocation, investment, and feeling valued by the patient. Drawing on these themes, a number of essential elements of nurse-patient connectedness were identified. For example, “nurse experiences some tension” and “patient shows some vulnerability”; “nurse and patient invest more in the relationship, each taking risks”; and “connectedness results” were all recognized as essential elements (Heifner, 1993, p. 14). Results of this study indicate that positive connectedness in the psychiatric nurse-patient relationship is thought to improve the efficacy of the therapeutic relationship. These findings, from the psychiatric setting, might increase our knowledge and understanding of connectedness between the patient and the nurse. In addition, these findings can provide extant knowledge in conceptualizing the emergent theory in the study of connection within the nursing student-patient relationships.

Staff Nurse – Student Relationships

Staff-student relationships create another theoretical basis for developing knowledge in the area of nursing student-patient relationships. Clinical placements provide the opportunity for students to develop their knowledge, skill, and judgment (praxis). This is also the environment where students are socialized into becoming a registered nurse, that is, how the nurses think, feel, interact,

value, and communicate (Levett-Jones, Lathlean, Higgins & McMillan, 2009). Nursing students look to practicing nurses as role models.

Levett-Jones, et al (2009), explored the relationship between belongingness and placement experiences of preregistration nursing students. The results indicate that having a sense of 'belongingness' promotes an environment conducive to learning, and ultimately a better quality nursing student-patient relationship. Having knowledge about the types of interactions and behaviours, that is, receptiveness, inclusion/exclusion, legitimization of the student role, recognition and appreciation, and challenge and support, potentially facilitate or hinder students' belongingness and learning (p. 319-321). Having this knowledge may be critical in establishing positive connections among staff and students and in the selection of clinical experiences. For example, if nurses are aware of how to establish a 'positive connectedness' with students and patients, and the benefits of maintaining the therapeutic relationship, the intensity of the work environment may still be a reality, however, there may be a renewed energy, enthusiasm and satisfaction to do the work. Also, this would demonstrate positive role-modelling for students.

Research has shown that nurses have a tendency to attend to the physical care of patients, and engage in habitual, superficial ways with little social and emotional interaction (Caris-Verhallen, Kerkstra, Bensing & Grypdonck, 2000; Pound & Ebrahim, 2000; Suominen, Leino-Kilpi & Laippala, 1995). Gordon, Ellis-Hill, and Ashburn (2009), found that nursing staff controlled interactions with patients by using short closed questions which limited their ability to interact

therapeutically. These registered nurses are the role models who might be facilitating the teaching/learning process of the therapeutic nurse-patient relationships in practice for students (Hartigan-Rogers, Cobbett, Amirault & Muise-Davis (2007). Although staff nurse and student relationship is not exclusive, it does demonstrate the contribution this theoretical base could potentially add to the knowledge development for nursing student-patient relationship, and more specifically the concept of connection.

Faculty-Student Relationships

With the advent of the humanistic approach in nursing education prior to the 1980s, the pivotal shift and central focus for the nursing education process became the student, and what later became known as the interactions between student and teacher in the curriculum (Gillespie, 2002, 2005). Basically, this was the momentum for the development of the connected student-teacher relationship, a transformed relationship reflecting an equitable partnership and fostering a culture of growth for both student and teacher. Gillespie (2002), asserted that connection within relationships to date remained obscure and that connection was an unexplored part of the practice of nurse educators. Interestingly, other anecdotal literature was discussing teaching perspectives that incorporated or supported student-teacher connection at the same time (Gilligan, 1993), largely from a feminist orientation, such as promoting students' self-esteem and personal growth (Bargad & Hyde, 1991). In addition, Gillespie found scant research to support claims of an optimal student-teacher relationship, and the presence of connection, influencing positive results on learning outcomes.

Gillespie conducted a study to explore and describe undergraduate nursing students' experiences of connecting with the student-teacher relationship, and the effects of student-teacher connection on students' learning experiences in clinical nursing education. She uses qualitative interpretive descriptive design for the study. Eight participants, representing all years of the undergraduate program, participated in unstructured interviews. Six of these eight participants participated in a subsequent focus group to confirm and expand understanding of the participants' experiences. Constant comparative analysis was undertaken throughout the data collection process. Four interrelated themes emerged from the coding within and coding across categories producing a description of students' experience of connection in the student-teacher relationship: nature of connection, formation of connection, processes of connection, and outcomes of connection. The nature of the connection was both professional and personal components, that is, the relationship focused on the students' learning and personal information was shared if it was appropriate to the learning situation. Students commented that they felt valued and respected in connected relationships. In a non-connected relationship, the focus was only on work with minimal or no personal sharing between student and teacher.

Forming a student-teacher connection emerged as being a 'highly interactive' and 'evolving' relationship. Essential to the formation of connection were communication, mutual knowing, trust and respect. 'Beginning' the relationship and 'interpreting' were influencing processes within the evolving nature of the relationship. All processes were circular in nature in that student and

teacher were being influenced and influenced each other. Teachers' competence, compassion and commitment were all integral to a positive connecting relationship with students. For example, attributes related to compassion are also essential components of competence and commitment. Further, teachers who were 'connected' were viewed differently than non-connected teachers. The connected teachers were able to teach more than the physical aspects of nursing, and helped students develop skill requisites and processes such as organizational and communication skills and clinical judgment. Having recent clinical experience was an asset to being a connected teacher, as practical knowledge helped them support students to navigate the real world of nursing. In addition, teachers who lacked confidence distanced themselves from students thus inhibiting knowing and connection. Teachers who used their knowledge to support student learning were viewed as being connected, compared to teachers who used their knowledge to point out the differences between teacher and student roles.

The teacher's way of being and the way of teaching are critical elements for connected student-teacher relationship. These included spending time with students, being genuine, providing time and actively 'listening' to what the student says. In 'non-connected' relationships, the students centered their attention on appeasing the teacher, for example, 'getting it right', as opposed to focusing on their own learning, and connecting with the big picture of the patients' experiences. According to Gillespie's work, the students' stories revealed that 'fit' between teaching and learning styles are key, however, personal

characteristics such as personality, interests, communication styles, background and values, are fundamental to the formation of connection.

Gillespie (2005), reflecting on her 2002 work, reviewed the existing understanding of student-teacher connection relevant to the tangible and measureable outcomes of connection. She then examined the essence of connection, that is, the qualities that it exemplifies: trust, knowing, respect and mutuality. With this increased understanding, Gillespie was able to portray how the student-teacher connection could be 'a place of possibility'. A teacher-student connection is possible by creating a transformative 'cosmos' where students are acknowledged for what they know and do. They can consolidate knowledge and skills, gain insight into their capabilities, and develop their personal and professional capacities. Further, 'connection' with its inherent properties of trust, knowing, respect and mutuality, establishes the possibility for a learning environment that fosters transformation and growth and professional socialization for the student and teacher.

Diekelmann (2001), using a longitudinal (12 years) narrative pedagogy (Heideggerian Hermeneutical analysis), produced the 'Concernful Practices of Schooling Learning Teaching' describing how teachers, students and clinicians experience teaching and learning. Ten 'patterns' emerged from the data: "gathering, creating places, assembling, staying, caring, interpreting, presencing, preserving, reading and writing, thinking and dialogue, and questioning" (p. 57). The 'staying' pattern has the properties of knowing and connecting that were discussed earlier in this chapter. Diekelmann and Mikol (2003) pose the question

"…are the practice of knowing and connecting lost in an educational milieu where teaching and learning are subsumed by competing demands?" (p. 385). The importance of this work highlights the possibilities for students, faculty and clinicians to embody these concernful practices to enrich the educational endeavour. What is not clear are the social psychological processes that facilitate 'connecting' and come to know in order to build meaningful relationships to know and connect therapeutically.

Nursing Student-Patient Relationship

Suikkala and Leino-Kilpi conducted research on student nurse-patient relationships in 2001 and 2005, and then again with Katajisto in 2008. In 2001, Suikkala and Leino-Kilpi completed a review of the literature published between 1984 and 1998. This review was groundwork for an empirical study focusing on the nursing student-patient relationship. They searched MEDLINE and CINAHL databases using the key words: 'nurse-patient relations', 'nursing students' and 'student-patient relations'. The search produced 484 articles. A key finding revealed that research in this subject area increased steadily after the 1980s. Inclusion criteria for this review was empirical research articles published in English or Finnish that included nursing students, other health care students, clients or patients forming all or part of the sample population. This reduced the number of articles to 364. Two theoretical articles that focused on 'using clients' and 'concept analysis and critical thinking: integrated processes' were deemed relevant to the subject area and were included in the review. Further exclusion of

non-empirical articles, anecdotes, news and editorials, left 104 articles for analysis.

Content analysis was used to identify, code and categorize the data into a broadly interpreted six point classification scheme. The classifications were sources of information, research methods, student perspective on experiences and perceptions and attitudes, patient perspective on experiences and perceptions, students' interpersonal skills and effects of teaching methods. The result section provides a comprehensive analysis for each classification.

Suikkala and Leino-Kilpi (2001) summarized the results of this review of articles into three main points. First, 'student-patient relationship' has been studied, however, not in great depth. Second, interest in this subject area used qualitative and quantitative methodologies with most of the studies being descriptive in nature. Third, although the focus is on student perspectives of experiences, perceptions and attitudes and patient perspectives within the relationship, the latter perspective has not received a great deal of attention. In addition to these perspectives, some attention has been given to nursing students' interpersonal skills and the effects of teaching methods.

More knowledge is required about the nursing student-patient relationship, specifically knowledge that is grounded in different theoretical perspectives. Moreover, the nature of the relationship and the roles of student and patient in the relationship from their perspectives needs to be explored. Additional research is required to uncover the effects of this relationship and what it means for the students' clinical learning and quality outcomes for the patients.

Suikkala and Leino-Kilpi (2005), building on their 2001 work, conducted a qualitative research study to explore nursing students' and patients' experiences of their relationship. In this study, the co-investigators wanted to describe: the main features of the relationship, who the participants were and what they did in this relationship, the features of the relationship, and the significance of the relationship for the student and the patient. At the outset, the authors stressed the importance of having both the students' and patients' viewpoints given both could benefit from the relationship. At one university hospital in Finland, purposive sampling was used with nursing students (n=30) studying in a baccalaureate level program, and patients (n= 30) hospitalized on a medical ward for 3 days or more. The students' clinical placement had to coincide with that of the patients' stay on the ward. The students and patients were selected based on their ability to converse about their knowledge of the subject matter. Ward managers served as contacts interested patients. The data were analyzed using qualitative content analysis. The unit of analysis was a complete thought (a single word or several sentences). Data were coded, categorized and culled into themes, drawing on ideas and thoughts from the text. The results of this study revealed three types of relationships which are presented here in ascending order of participation or involvement: mechanistic relationship, authoritative relationship, and facilitative relationship. These relationships will be presented individually, inclusive of the following categories: main features of the relationship and activities and actors in the relationship. Factors associated with the relationship and significance of the relationship will be addressed separately.

Main features of the mechanistic relationship, from the students' perspective, reflected a need to focus on their own learning needs, that is, acquiring knowledge and technical skills. Being task oriented, the students relied on direction and advice from others (nurse, physician's orders), and basically performed physical care. There was little to no interaction with the patients; usually the students and patients did not know each other. Students in this type of relationship were seen as passive observers of information from 'others' (nurses), and considered these nurses their role-models. They focused on perfecting technical skills according to a script (nurse's order or nursing care plan). These skills were practiced on the patients (passive recipients) who usually benefited from this activity. Patients were observers of student actions and not as active participants in their care. The authoritarian relationship was characterized by students assuming that they knew what was best for the patients. Students took the lead and planned the activities for the patient based on their (students) assessment and knowledge of patient needs. Patients could potentially contribute to their care plan. However the relationship between the students and the patients was viewed as superficial, thus inhibiting the students from act in a patient-centered way. Interaction consisted of the patient knowing the student by name and being interested in the student on a more personal level. For both students and patients there seemed to be a level of informal, social conversation. In this relationship students were seen as active helpers and advisors, and were also expected to make decisions about patient health and care. As in the mechanistic relationship, the patients were regarded as passive recipients of care. Despite students giving

information, teaching patients to solve problems, and motivating them, the patients did not seem to share their (patients) own views about their care. Focusing on the 'common good' for both the student and the patient represented a facilitative relationship. Collective points of view regarding action to be taken were centered around equality, appreciation, mutual support, caring and understanding. The relationship was directed by the patients and their care requirements, in other words, patients guided their own care. In this relationship, the students and the patients seemed to genuinely take an interest in each other. This allowed for an open and 'confidential interaction', creating a 'safe' environment for the patients to explore their viewpoints. Students assumed the role of listener and advocate in the facilitative relationship. They showed a genuine interest and understanding of the patients' wellbeing. They listened to the patients' personal opinions and requests and responded accordingly. Patients were considered experts in their own health and welfare. As well, patients contributed to students' learning by providing positive and somewhat opinionated feedback.

A number of factors were identified as facilitating or impeding the development of a 'well-functioning relationship'. These included some student related factors, patient related factors, length of time spent together, and the environment where the activity took place. For example, good role models in the environment facilitated positive student patient-relationships. Negative feedback from staff nurses impeded the development of a positive student-patient relationship. Well functioning relationships resulted in positive consequences for students' personal and professional growth including an expanded theoretical

knowledge base, increased confidence and self-esteem and increased trust in their own abilities and possibilities. Patients benefited from the relationship with an improved state of health and self-care and a satisfaction with the students' genuine presence.

Students' relationships with patients and the implications of these relationships in clinical practice and learning warrant further study. In addition, information from this study emphasizes the need to mentor students in interpersonal relations and to coach students to include patients in decisions of care. This study also confirms findings from earlier studies which suggest that students seem to move through a trajectory from mechanistic relationships, to authoritative relationships to facilitative relationships while simultaneously gaining more knowledge, skills and patient relationship experience. As trust in their own abilities grew, so did their confidence and self-esteem. These authors suggest that the next step would be to use a quantitative approach to test the categories that became apparent in this study. Suikkala and Leino-Kilpi (2005) also suggest two other considerations for study: ranking the importance of interpersonal relationships for students and supervising nurse staff, and studying relationships in other clinical placements.

Suikkala, Leino-Kilpi and Katajisto (2008a), conducted a subsequent study, a descriptive comparative design, to describe and compare nursing students' and patients' perceptions of the relationship between students and patients. The authors note that clinical placements account for 36 to 43% of degree programs. Students must work directly with clinical nursing teachers and

unit staff to develop competencies and skills requisites in each practicum, to foster their professional growth. In this context, patients also offer a valuable role in assessing student learning by providing feedback to students and clinical nursing teachers. A convenience sample of nursing students (n=290) and internal medicine patients (n=242) were recruited from five university hospitals and five central hospitals throughout Finland. Structured questionnaires were developed for the study, and were based on work of student-patient relationships previously undertaken by these authors: a literature review in 2001, and a study that used semi-structured interviews in 2005. The questionnaires included items of three types of student-patient relationships: mechanistic, authoritative, and facilitative. Two additional groups of items were included in the questionnaire: contextual factors, for example, the ambiance within the context during collaboration; and consequences related to the type of relationship, for example, students' personal and professional growth. Other than background and demographic information, the patient and student questionnaires included parallel items. After expert review, the questionnaire was revised and pilot tested with a convenience sample of 33 nursing students and 28 patients on one internal medicine ward in a university hospital in Finland. Following the pilot test, two items were removed and some wording was addressed to enhance item clarity. Principle component analysis was used to replace construct validity to ensure the items in the questionnaire were measuring the theoretical construct extrapolated from the literature review (2001) and the interview study (2005). Data collection took place between September 2005 and May 2006. Three hundred and ten student questionnaires and 310

patient questionnaires were distributed. Two hundred and ninety-two student questionnaires were returned, two of which were blank. Two hundred and eighty-nine patients agreed to participate, but only 277 questionnaires were returned. Of these, 35 were excluded because of missing data. Therefore, 290 student questionnaires and 242 patient questionnaires were used for data analysis.

Results of this study indicated that students consider themselves, in the nurse-patient relationship, to be more authoritative and facilitative than patients do, and that patients consider the relationship as more mechanistic than students do. Students felt they were practicing in a patient-centered way, that is, helping and supporting the patients when providing nursing care. The patients saw themselves as the recipients of nursing care. This study demonstrates that patients can provide useful feedback for student learning and how to enhance their practice.

Another aim of the Suikkala, Leino-Kilpi and Katajisto's (2008b) study was to describe factors relating to the nursing student-patient relationship from the students' point of view, that is, background variables, contextual factors, and consequences of relationships that could be related to their views on the type of relationship (mechanistic, authoritative, facilitative). A student-patient relationship scale and a sociodemographic questionnaire (age, gender, education and working experience) were used to collect data. The students' ages, year of study, support persons other than supervisor, perception of patients' attributes, and the atmosphere during interactions were important to the type of relationship. The only student variable that significantly predicted a facilitative relationship

was the students' age; older students in these relationships may have "a more positive perception of the patients attributes as a patient" (Suillala, Leino-Kilpi, & Jouko, 2008b, p. 539).

Morgan and Sanggaran (1997) used constructive feedback from patients of mental health facilities and concluded that clients were willing to participate in students' learning, and that students felt patients had a valuable role to play in their learning. A key recommendation from this study was that patient feedback could "assist students to enhance their professional self-awareness through providing a perspective that encompasses the total nursing experience" (p. 434).

The student-patient relationship is a significant concern. The authors reiterate the significance of the professional nurse-patient relationship with regard to enhancing quality nursing care. There is a need to do further studies to learn more about this relationship, and that this relationship cannot be emphasized enough in clinical learning. A grounded theory study in which a theory emerges from the data (nursing student-patient relationship, in particular connection), would also bring to light the basic social processes, such as reflection and self-awareness, inherent in such a relationship. In addition, this knowledge could further inform the development of a formalized role for patients to share their feedback to students and clinical teachers in a meaningful and sensitive learner centered approach. Prior to discharge, perhaps a structured questionnaire that reflects key elements of being in a relationship such as trust could be given to the patient and family to complete.

Nursing students have been studied in a variety of ways since Suikkala and Leino-Kilpi's (2001) research. Research interest in this area has focused mainly on the student perspective (Suikkala & Leino-Kilpi, 2005). Researchers have studied the student experiences related to clinical placements. Hartigan-Rogers, Cobbett, Amirault and Muise-Davis (2007) studied the perceptions of newly graduated nurses regarding their clinical experiences (in the 3rd and 4th year of their educational program) and how these placements influenced their functioning as a nurse. Using a descriptive research design, they undertook a pilot study with new graduates (n=3) to test a semi-structured interview guide specifically designed for this study. Based on the results of the pilot study, a larger study was conducted. Four themes emerged from the larger study (n=70): developing nursing skills and knowledge, experiencing the realities of work-life, preparing for future work, and experiencing supportive relationships. Students were more inclined to go back to practice as a graduate on a unit that was supportive and encouraging toward the student. For example, students were hired into specialty areas such as intensive care units where they experienced these units as having better staffing, more resources and where there was more support for students' learning needs and social relational support. Medical- surgical units were not viewed in this regard. It was more difficult to establish relationships on these units. Tuohy (2003) and Chan (2004) agree that effective nurse-patient communication is critical in developing a positive therapeutic relationship.

Orland-Barak and Wilhelem (2005) used a phenomenological-hermeneutical approach to study twenty-four novice student nurses' perspectives

about learning to become a nurse. Using students' language and content of written stories about their clinical practice, three characteristics were identified: procedural language, medical terminology as opposed to nursing terminology, and a focus on actions instead of interactions. The authors stress the importance of designing a curriculum that highlights the importance of multidisciplinary characteristics of practice and making connections relating action, interaction, thinking and emotion.

Andrews, Brodie, Andrews, Hillan, Thomas, Wong, et al. (2006) conducted focus group discussions (n=7) and an interview survey of ex-students (n=30) to investigate the students' experiences and perceptions about their clinical placements. One of the findings from this study revealed that the model of learning in placement continues to be the apprenticeship model whereby the student learns by listening and watching. They offer a number of practice models as examples to engage the faculty, staff and student in a more interactive learning community that could facilitate the social and professional interaction necessary to develop the positive connections required for effective therapeutic nurse-patient relationships.

Ironside, Diekelmann and Hirschmann (2005a) conducted a Heideggerian hermeneutical pilot study to explore undergraduate students' experiences in making a difference in practice settings. Connecting and knowing was a pattern that emerged from every interview. The authors suggest that knowing and connecting is a critical aspect of quality patient care. They describe the physical actions of the student nurses in patient encounters. However, they did not elicit in

detail the basic social processes required of a nursing student to know how to connect with the patient. Specifically, they found that despite difficult and eventful situations in the health care environment, teachers and students can explore potential avenues for knowing and connecting with patients. In fact, this knowing and connecting is critical to learning nursing and is an aspect that provides students with the support necessary to prepare for and work in the practice environment. Ironside, Diekelmann and Hirschmann (2005b) reported that even in suboptimal circumstances students were able to listen and respond to their patients, thus finding ways to know and connect with the patients. This finding has important implications for clinical nursing faculty, such as knowing how students make meaning of events in their clinical practicums. A theory grounded in data would provide a framework to further explore the social psychological processes with students, faculty and patients adding to the substantive knowledge of this interconnected relationship.

Other researchers explored students' perceptions of and attitudes toward patients and the caring situation. Leners, Roehrs and Piccone (2006), conducted a quantitative, longitudinal study (four cohorts of nursing students) using a pre-test (n=159), post-test (n= 128) survey (Nursing Professional Values Scale [NPVS]) design that measured professional values at different times over a three year period. An interesting finding was that the least-valued NPVS items was professional socialization into the nursing discipline. However, nursing students did rate nurse-patient relationship values higher than multidisciplinary collaboration values.

Karaoz (2005), completed a qualitative study in Turkey using interviews as means to have 4th year nursing students (n=19) describe incidents in which they observed nursing behaviours in caring and non-caring ways. Seven of 19 students did not observe caring behaviours in the practice setting. Two themes emerged from the data: professional/helping relationships and technical competency. The four basic characteristics of the professional/helping relationship were respect, compassion, concern and communication. The authors described examples of caring and non-caring behaviours for each characteristic. In addition, the students reported that technical competence of the nurses (knowledge, skills, and currency) was lacking. The authors conclude that respect for personhood is a basic component for nurse-patient relationships and basic ethical care.

Shellman (2006), utilized a qualitative study using survey design with open ended questionnaires to gain insight into baccalaureate nursing students' (n=41) perceptions of their reminiscence experiences with older adults. Three themes emerged from the data: making a connection, seeing the world through their eyes, and benefits of reminiscence. I will focus on the theme of "making a connection". Students felt that when they asked the patients' about their past, the patients were able to share part of themselves, their memories (good and sad), and that the student and patient communication improved and the students anxiety levels decreased. Students felt they made connections with their patients' and described this connection as being on a different, more personal level with the patients. I believe this work is important to help us understand the importance of making connections, and that asking patients about their past experiences can

initiate the conversation. However, it does not elicit the basic social processes, such as putting oneself in the right frame of mind, to allow the connection to happen in the first place.

Hweidi and Al-Obeisat (2006) conducted a study to identify Jordanian nursing students' attitudes toward older people and whether they considered the attitudes of this group about the care given to patients. Using a descriptive correlational design, Kogan's Attitudes toward older people tool, and a convenience sample of 250 nursing students enrolled in a bachelor of nursing science program at a government university, students' attitudes were identified using descriptive and inferential statistics. A key finding in this study was that Jordanian nursing students demonstrated marginally positive attitudes toward older patients. Also, senior and male nurses displayed more positive attitudes than did their counterparts. The findings from this study suggest that more work is needed to enhance these positive attitudes toward older patients. This work is crucial as attitude is a part of the behaviour in developing a therapeutic nursing-patient relationships. Further, attitude may be a basic social process that could emerge from the data in a grounded theory study on nursing student-patient connection.

An interesting finding from a study conducted by McKinlay and Cowan (2003) was that nursing students demonstrated positive intentions toward working with older patients, and they believed that their behaviour was under volitional control. Using the theory of planned behavior the researchers sought to draw upon participants' own understandings about what they felt was important about

working with older patients. The sample consisted of 12 male nursing students and 160 female nursing students from three educational institutions in Scotland. The mean age was 23.2 years, the nursing students were in different stages of their program, and held a variety of previous experience with older people. A questionnaire was developed for the study utilizing elements from Kogan's Old Person Scale and Palmore's Facts on Aging Quiz, along with two vignettes that described different nursing behaviour orientations working with older patients. Vignette A focused on the importance of working with older patients with the attitude that they took up space, and that there was not where else for them to go. Vignette B focused on the importance of hospital- based care with older patients who required only basic nursing care. Findings from this study indicated that students had positive intentions towards and attitudes about working with older patients, and that their intentions were likely dependent on their attitude.

Another area of research focuses on interpersonal skills. For example, students need opportunities to develop and enhance their interpersonal skills, especially mentoring opportunities, and be assigned to practice placements that are conducive to learning. Ashmore and Banks (2004) conducted a study using Heron's six category intervention analysis framework with a convenience sample (n=46) to analyze student nurses' actual skills as positioned in clinical role-plays and to compare these findings to earlier work. Six interventions in rank order were produced: "catalytic, prescriptive, supportive, informative, confronting, and cathartic" (p. 20). Students in this study used catalytic interventions, that is, drawing out information and promoting self-understanding, the most.

Interestingly, the authors indicate that in previous studies, both students and nurses perceived themselves to be poor in these interventions. Morrison and Burnard (1989) categorized these six interventions into authoritative (maintaining some degree of control) and facilitative (enabling the locus of control to remain with the patient) categories. The catalytic component was categorized as facilitative. Reflecting back on Suikkala et al's work (2005, 2008), the students assessed themselves as facilitative and authoritative, yet the patients assessed them to be more mechanistic. My point is how do nurses perceive themselves and how they actually practice? These points become an important aspect of the nurse-patient relationship if there is a disconnect here. This also has implications when role-modelling behaviour for nursing students who are looking to the nurse for guidance in developing therapeutic relationships.

Using hermeneutic phenomenology, Idczak (2007) uncovered how nursing students learn to experience being with patients. Biweekly for four hours, nursing sophomores (n=28) engaged in interviews and interactions with patients in a clinical setting. The students were asked to electronically record their thoughts, feelings and emotions related to their experiences interacting with the patients. Five themes of how nursing students made meaning emerged: "fear of interacting with patients, developing confidence, becoming self-aware, connecting with knowledge, and connecting with the patient" (p. 68). One example of 'connecting with the patient' was described by being patient and willing to spend time with the patient…felt she was making a difference in the patient's life. This supports the notion that student-patient relationships and its inherent interaction are

important aspects to nurture. A theory grounded in data regarding the basic social psychological processes, (e.g., fear), could provide substantive knowledge in this area.

Conclusion

Seeing the person as a whole in a therapeutic relationship helps us to understand that objective science *alone* cannot provide the philosophical orientation or methodology necessary to develop nursing knowledge in this area (Gortner, 1993; Meleis, 2007). Nursing student-patient relationships ought to be studied with different philosophical and methodological approaches. We need more knowledge about how nursing students connect with patients in a more therapeutic and facilitative way that is responsive to patients' needs in order to promote quality and meaningful lives for patients and students. As patients are part of the relationship, more studies are needed to elicit the patient perspective, thus adding knowledge and developing theory for nursing students to enhance their practice. Moreover, students require role models and practice environments that facilitate the students' development of expertise, challenge and change their present ways of being, and develop new ways of knowing and doing (Bail, 2007; Vanhanen & Janhonen, 2000).

In summary, the theoretical basis and empirical research described above supports the need to focus nursing research on the development of nursing knowledge in the area of the student-patient relationship, and the process of connection within this relationship. Few studies focused on understanding the

dimensions of the relationships between nursing students and patients. No studies examined the process of connection within the student-patient relationship.

CHAPTER III

RESEARCH METHOD

In this chapter, I discuss the research method that was used in this study. The theoretical underpinnings of the Glaserian grounded theory method are discussed followed by ethical considerations, sampling, data collection strategies, data analysis techniques, and a description of strategies used to ensure rigour. I conclude this section with ethical considerations.

Theoretical Underpinnings of the Research Method

The Glaserian grounded theory approach was chosen for this study. This method was suitable for this study because of its genesis in symbolic interactionism, which acknowledges that humans gain meaning from their interaction with others, and pragmatism, which accepts that theoretical knowledge is not superior to practical knowledge (Annells, 1996; Cutcliffe, 2000). No specific conceptual model of nursing, or a model from another discipline, informed the approach for this study (Heath, 2006).

Symbolic Interactionism

The foundation for grounded theory methodology can be found in symbolic interactionism (Schreiber & Stern, 2001). Symbolic interaction emerged from the philosophy of pragmatism. Epistemological roots can be traced to philosophy, education, psychology and sociology. Symbolic interactionism originated with the work of George Herbert Mead in the 1920s, and Herbert Blumer further developed the theory in the 1930s.

Plummer (1996) emphasized four interweaving themes that reflect the fundamental nature of symbolic interactionism. The first theme is about human worlds (Annells, 1996). Not only are human worlds objective, they are also incredibly symbolic. Our social life is expressed through symbols, such as gestures and words, and the most symbolic is said to be our language (Annells, 1996). A second theme relates to a dynamic life process that is continually in flux: evolving, emerging, and becoming. The third theme recognizes that a person does not develop in isolation of their surroundings. Interactionists endeavour to uncover what symbolic meanings have for groups through the process of interacting with one another (Plummer). This interaction provides the medium for people to create meaning and construct their own realities (Morse & Field, 1995). Moreover, grounded theorists interview for meanings fashioned in these social relationships. They want to discover how groups of people describe their realities on the basis of their understandings of interpersonal interactions. Basically, humans come to know the collective social meaning through social interactions, in other words, the individual or self is created out of this socialization. The fourth theme emphasizes the interactionist's commitment to and focus on the real world, and not abstract theory. Studying the empirical word directly provides the foundation for interactionist's inquiry.

The four themes guided my study of the process of senior nursing students connecting with their patients. The language and contexts of the nursing students, for example, practicing on medical-surgical units, helped me to figure out how they see themselves and their behaviour and perceptions, especially as they relate

to nursing students connecting with their patients. By focusing on the real world, I dealt candidly with what was currently taking place, as well as what the participants think did happen or ought to happen. Based on the ontology of symbolic interactionism, the classic (Glaserian) grounded theory method is concerned with the characteristics of a 'real' reality (Annells, 1996). Glaser (1992) agrees, saying his method (classic) concentrates on the "concepts of reality" (p. 14), looking "for what is, not what might be" (p. 67), at the same time searching for "true meaning" (p. 55), and that the emerging grounded theory "reality exists in the data" (p. 53).

Pragmatism

Doubt and belief are necessary elements of a constantly evolving learning process (Leary, 2009). Since knowledge development is value-laden and historically contextualized, and values are important components of pragmatism, a process of inductive exploration is required to uncover differences in perspectives and meaning within context. Moreover, truth, in this context, cannot be derived from a priori theory, that is, by engaging in deductive analysis. Truth is individualistic and subjective, and all possible truth is said to be practical (Leary). This process of inductive exploration and the subjective nature of 'truth' provided the substance for rich and meaningful dialogue regarding notions of 'truth'.

In summary, based on pragmatic epistemology, this classic grounded theory study was concerned with getting to know the process(es) of senior nursing students connecting with patients. In addition, the aim of the study was concerned

with getting to know the perceptions of clinical nursing faculty in relation to this student-patient connection.

Grounded Theory

Grounded theory is a valuable method to utilize when the goal is to identify, describe, and represent knowledge in a field of inquiry where few data exist, such as the idea of connection in the nursing student-patient relationship. By using experiential data, grounded theory was used to identify complex and covert processes, for example, those related to ‘connection’. Grounded theory was beneficial in studying ‘connection’ because it could be utilized to help discover and speak about connection within relationships, what influences it, and the behaviours and actions associated with this in a dense, rich fashion.

In nursing, the main interest in using grounded theory has been for the purpose of micro level analyses. Perspectives and interactions of individuals that shape their daily lives would be addressed by micro level analyses. Micro level analyses of social and psychological processes tend to be where grounded theory analyses is focused, as opposed to social structural processes which are macro level analyses (Schreiber & Stern, 2001). Grounded theory was used in this study to try to comprehend the question or concern from the point of view of the individual who is affected by it.

Current discussions advocate that grounded theory can be utilized to contemplate both macro and micro level analyses (Morse, 2012; Morse, Stern, Corbin, Bowers, Charmaz & Clarke, 2009; Schreiber & Stern, 2001). For example, macro level analyses can be carried out in relation to economic,

political, cultural and organizational factors at a community and societal level that affect the nurses' and patients' abilities to develop therapeutic relationships (nursing shortages, economic downsizing, political climate, infrastructure). In this sense, micro and macro fields are mutually interdependent and influence each other. Having its foundation in symbolic interactionism, grounded theory is based on the relevance of the processes of interaction and how individuals and groups play a role in creating social environments. Since grounded theory can be used to analyze and conceptualize at both the micro and macro levels, it was a good fit in articulating knowledge regarding senior nursing students connecting with their patients.

The basic aim of the grounded theory method is the generation of theory from data, and therefore explaining how the main problem in a study is processed or resolved (Cutcliffe, 2000; Glaser, 1978; Glaser & Strauss, 1967; Glaser & Strauss, 1995). Both inductive and deductive reasoning are utilized in grounded theory (Schreiber & Stern, 2001). In the beginning, I inductively gathered data and then created suppositions which were confirmed or disconfirmed during successive data collection. For the entire data collection and analysis phase, I constantly asked myself, "What is this data a study of?", "What category or what property of what category does this incident indicate?", and "What accounts for most of the variation in processing the main problem that makes life viable in this situation?" (Glaser, 1992, p. 4). These questions helped me to stay focused. It was important for me to stay focused on what was actually happening in the participants' world, and not on my personal opinions and assumptions. The

participants were the authors of their own story, and I continually deferred to them to understand meanings, realities, and behaviours in their context.

Constant comparative analysis technique, a core characteristic of grounded theory, was used as the groundwork for my analysis and theory generation (Glaser, 1978, 1992). As part of this technique, data were constantly analyzed, compared, checked and refined, as they were generated (McCallin, 2003). This kind of comparison was important as it formed the starting point for decisions regarding theoretical sampling, specifically, if and where to look for the next relevant data. When additional data did not add new information or anything different to a category or the emerging theory, then data collection stopped and saturation was said to have occurred (Glaser, 1978).

Theoretical sensitivity forms the basis for grounded theory research (Glaser, 1978, 1992). Theoretical sensitivity refers to personal qualities of the researcher. I remained insightful, was able to make meaning of and give meaning to the data, and was able to separate germane data from irrelevant data (Strauss & Corbin, 1998; Glaser & Strauss, 1967, 1995). I was receptive and sensitive to the narrative that was presented by the participants in the study (Glaser, 1992). In addition, I was able to discern what was significant in the data and give it meaning. A continuous process evolved looking for patterns that could suggest emerging categories and their properties, and identifying emerging relationships between the categories (Glaser, 1978, 1992). I kept in perspective that the emerging theory must be derived from the data and not forced from the data (Glaser, 1992).

The researcher's theoretical sensitivity can be enhanced by keeping up to date with extant literature. Glaser (1998) stated "the researcher should be reading vociferously in other areas and fields while doing grounded theory in order to keep up his theoretical sensitivity" (p. 73-74). I remained 'super-sensitive' to the emergence of categories, their properties and relationships without any preconceived ideas (Glaser, 1998). Pursuing knowledge in related and unrelated fields can help the researcher expand on ideas about one's own phenomena under study (Schreiber & Stern, 2001). Using the literature for differences and similarities with emerging categories helped me to avoid forcing the data. Moreover, this literature became a data source, along with other sources of data such as focus group interview data. Keeping a critical perspective when reading the literature, taking advantage of the literature to stimulate insights toward the emerging theory, and not favouring the literature with respect to the emerging categories, properties and relationships, helped me to enhance theoretical sensitivity capability, a vital component in a grounded theory study.

Outcomes of the grounded theory method may contain interpretive and theorizing components, and most research will present both types of outcomes (Schreiber & Stern, 2001). The focus for interpretive outcomes is on the holistic representation and dense description, and not on weakening the authenticity of this component with other theory and shared concepts. Further, theorizing outcomes tend to build on and refine concepts and theories that assimilate variations into an explanatory model. This study accentuated the interpretive-descriptive representation of outcomes and findings. This type of outcome was

important as there was little known about the topic. As this was an initial grounded theory study on the topic of senior nursing students connecting with their patients, I anticipate that additional research will be needed to build a more formal theory in which concepts identified in this research study would be further refined.

The 'basic social process' (BSP) is a central concept in grounded theory method (Glaser, 1978; Glaser & Strauss, 1967), and the grounded theory is developed around this core category (Reed & Runquist, 2007). The BSPs are defined as "fundamental patterns in the organization of social behaviour as it occurs over time" (Glaser, 1978, p. 106). Hence, the grounded theory method "must focus on answering the conceptual question" (Benoliel, 1996).

In summary, throughout the entire study, these features of grounded theory happened simultaneously: theoretical sampling, the constant comparative method, coding and categorizing, memo writing, and theory generation (Jeon, 2004). These features are explained in more detail later in this dissertation.

Ethical Considerations

The Vice-Dean of the Faculty of Nursing of a large Western Canadian University was contacted with a formal letter (Appendix A) introducing the intended dissertation research study and to request permission to approach 4th year nursing students as well as clinical nursing faculty during a medical-surgical clinical course in Fall of 2009. The Vice-Dean provided permission (Appendix B). The proposal was submitted for ethical review and approval from the Health Research Ethics Board of the large Western Canadian University. Following

administrative and ethics approval (Appendix C), I contacted the Associate Dean of the undergraduate program and the 4th year Program Co-ordinator to inform them regarding the study purpose and procedures, and obtained information about the date, time and place of the students' course orientation. I introduced the proposed study to the nursing students at orientation and to the clinical nursing faculty at a faculty/course meeting.

The rights of the nursing students were protected in a number of ways. I was not involved in teaching the students. Student participation was entirely voluntary. In my absence, the students had the opportunity to determine their willingness to participate in this grounded theory study. The clinical nursing faculty who taught in the 4th year medical-surgical nursing course did not know if any of their students chose to participate in this study. The risks to the nursing student participants were determined to be minimal to nonexistent. The benefits to the individual participant were also deemed to be minimal. One participant did become emotional during the interview at which time I stopped audiotaping and allowed her the opportunity to regain composure, and converse as necessary. The participant was able to continue, and I asked the participant after the interview if there was a need for follow-up. The participant declined follow-up.

Similarly, the rights of the clinical nursing faculty participants were protected in a number of ways. I was not a member of the Faculty of Nursing of this University, nor did I have other encounters with these faculty members. Participation of the clinical nursing faculty was entirely voluntary. They had the opportunity to determine their willingness to participate in a focus group .

Participants were asked to sign a confidentiality statement regarding participant's contributions. The risks and benefits for participating in the focus group were determined to be minimal to nonexistent.

A list of code numbers and the corresponding names was kept separate from the actual data. To protect confidentiality, pseudonyms were used to identify scripts. Transcripts, tapes and the demographic data were stored in a locked filing cabinet in the Faculty of Nursing, at the University and will be kept for seven years. Only my supervisors and I have access to the raw data. Data analysis was expressed in aggregate format, not individually. I will seek approval from the health research ethics board if I plan to do secondary analysis of the data in the future.

Sampling

Purposive and theoretical sampling is used in grounded theory studies even though sampling in grounded theory is said to be 'theoretical' (Cutcliffe, 2000; Glaser, 1978, 1992). The initial sample was comprised of senior nursing students who had experience in the phenomenon of interest (nursing student-patient connection) and who could speak to this phenomenon. Theoretical sampling is a hallmark of grounded theory. It is defined as "a process in which continued sampling occurs concurrently with data analysis that has commenced immediately upon receipt of the data; the introduction of new data is directed by the gaps, unanswered questions, and underdeveloped ideas in the emerging theory" (Fassinger, 2005, p. 161).

The number of participants, or sample size, is not determined at the beginning of a grounded theory study (Glaser & Strauss, 1967; Richards & Morse, 2007; Schreiber & Stern, 2001). During analysis and as the theory emerged, more participants were theoretically sampled to provide substantive data to build the properties and categories. Sample size, then, was determined by the adequacy of the data. The number of participants recruited for this study was determined by the quality of the participants' experiences, the ability of the participants to reflect on and report their experiences, and the requirement for further theoretical sampling (Richards & Morse, 2007). The literature recommends recruiting a sample size of 20 to 50 participants (Creswell, 1998; Morse, 1994). Forty-one 4th year nursing students and seven clinical nursing faculty comprised the study sample.

Student sample. Inclusion criteria for nursing students to be in this study were: currently in the last year of a four year baccalaureate nursing program, enrolled in a course where practice occurs in an adult acute medical-surgical care setting; able to understand and speak English; and able and willing to reflect upon and articulate their experiences (Cutcliffe, 2000). These criteria were used for several reasons. Nursing students in the final year of the program had sufficient nursing knowledge and experience to be able to speak to the phenomenon of interest. Fourth year nursing students provided rich and varied perspectives on the experience of establishing connections with patients. These experiences supported the development of a dense and meaningful theory.

A total of one hundred and eighty-one students were enrolled in two 4th year medical-surgical clinical practicums. Ninety-one students were enrolled in the September cohort, and 90 students were enrolled in the November cohort. Fifteen students, or 17%, of the September cohort and 26 students, or 29%, of the November cohort comprised the student section of the study sample. Four men and 37 women, or 23% (about one quarter of the medical-surgical cohort), comprised the student section of the study sample. Females represented 90% of the sample. The age range was 20 to 53 years with a median of 29 years and a mean score of 21 years. Using age groups of 5 years, the largest group represented was 20 to 25 years, comprising 71% of the sample, with ages 21, 22 and 23 being the most represented. The most represented age was 21years, comprising 29% of the sample.

These men and women represented diverse demographics. Fifty-six percent of the student sample reported no health care experience prior to entering the program. Forty-four percent of the student sample reported related experience in health care prior to entering the program. One student was enrolled in a Bachelor of Nursing program in another province. Another student was practicing as a Licensed Practical Nurse. Other students reported employment doing direct patient care, ancillary services as laboratory technicians, and as volunteers in long-term care facilities.

The students reported a variety of employment experiences while enrolled in the program. Nine students (2%) were not working during their program. Twenty-four students (59%) were working as undergraduate nursing employees.

A number of other employment settings included a medical laboratory, a Doctor's office/clinic, rural hospitals, a community health promotion program, and the show-home of a home building company. Eleven students worked in homecare. One student was on a leave of absence from the program caring for a newborn at home.

Clinical nursing faculty sample. Inclusion criteria for the clinical nursing faculty in this study were: currently teaching in the 4th year medical-surgical nursing course, assigned to an adult acute medical-surgical settings, and able and willing to reflect upon and articulate their experiences. These criteria were set for a number of reasons. Clinical nursing faculty provided rich and varied perspectives about senior nursing students and patients relationships, in particular connecting with the patients. Clinical nursing faculty, who had varied backgrounds and nursing experience, shared perspectives that added to the development of a thick, rich and meaningful theory.

Eleven clinical nursing faculty taught in the 4th year clinical practicum. Seven clinical nursing faculty (63.63%) of the total clinical nursing faculty, comprised the study sample. All respondents were female. All reported post-secondary educational preparation in nursing. Fifty-seven percent of the respondents held a Master's degree and 43% of the respondents held a Bachelor's degree. The demographic survey revealed job titles in academe as three faculty lecturers, two sessional clinical tutors, one clinical tutor, and one clinical nursing instructor.

The years teaching in nursing education ranged from one to fifteen with the average number of years being 7.57 years. The number of years in nursing practice ranged from three years to thirty-eight years with an average of 20.85 years. Six respondents currently practiced in the service sector in addition to teaching. One respondent qualified her response with "my practice is with nursing students, not in service sector." Two additional clinical nursing faculty completed the initial contact sheet. When contacted, both faculty had double-booked their time. One faculty rebooked the time for the interview and was a no-show for the interview. Two attempts were made to contact the faculty member with no response. No further contact was made.

Recruitment

Following ethics approval, the recruitment of senior nursing students was accomplished in a variety of ways. The main advertising was at orientation sessions for students in the 4th year medical-surgical nursing course. I attended the orientation session for each of the six week course in the fall term 2009. I introduced myself (Appendix D) as a Doctoral Student in the Faculty of Nursing and gave a brief summary of who I was (from Ontario, Nursing Professor with undergraduate students, and a nurse for 35 years) and spoke to the class about the purpose of the research project and my request for participants in this study. I left them with an Information Letter (Appendix E) and Initial Contact Form to fill out (Appendix F) if they were interested in participating. I asked that all students put their forms in the envelopes provided. I returned at the end of the orientation session to pick up the envelopes. This approach ensured that no one knew which

students chose to participate. I also used an advertising poster (Appendix G), on the 4th year nursing student website and the 4th year bulletin board. As the intended audience for recruitment was university nursing students, the reported Flesch Kincaid reading level was grade ten.

Clinical nursing faculty, who were teaching the 4th year adult medical-surgical course, were invited to participate in a focus group interview. I sought permission from the 4th year co-ordinator and course leader to attend a pre-arranged clinical nursing faculty meeting. After introducing myself, the purpose of the study and my request for participants (Appendix H), I left an Information Letter (Appendix I) and Initial Contact Form (Appendix J) with each faculty member to complete if they were interested in participating. I asked that the forms be put into the envelope provided, and I returned at the end of the meeting to collect the envelopes containing the completed forms. I also posted an advertising poster (Appendix K) in the Nursing Undergraduate Teaching area where the clinical nursing faculty had their offices.

As a result of these recruitment strategies, I had a good response from the nursing students and the clinical nursing faculty. I stopped sampling for nursing student participants when saturation of categories occurred (Morse, 1995). I knew this when additional data did not reveal anything substantially new or different about the categories (Glaser, 1978). However, I did use the final six participants in the sample to confirm saturation, increase the scope and depth of the data and contribute to the reliability and validity of the findings, such as sharing the emergent theory with them and receiving confirmation (Hood, Olson & Allen,

2007). In addition, a participant in the focus group commented “This, I believe represents a snapshot of what the relationship between the “parties” [students and patients] is”. These additional perspectives helped to make sure that the categories, their properties, and the emergent theory were derived from the utmost degree of scope and depth .

Data Collection

A variety of data generation strategies are using the grounded theory method (Schreiber & Stern, 2001). These strategies include interviews, observation, review of written documents, and focus groups (Glaser & Strauss, 1967, 1995; McCann & Clark, 2003 a&b). The primary methods of data collection for this study were semi-structured and open-ended interactive interviews with individual senior nursing students and one focus group interview with clinical nursing faculty. I conducted all the research interviews and was able to foster candid and open interactions with the participants, thus helping to ensure the validity of the findings. Direct contact with the participants gave me the opportunity to experience the influences within context, and to observe non-verbal communication which provided another source for rich, meaningful data, and ultimately my findings.

In human interactions, the element of power is always present (Nunkoosing, 2005). My power rested in my authority as a seeker of knowledge and procedural experience (Nunkoosing, 2005). In this study, the participant assumed the position of the privileged knower. Reflexivity is the process of reflecting critically on myself. I was aware of my personal impact on participants

during the interviews and focus group session. Sharing an appropriate 'story' initially with the participant, helped create an environment for reciprocity.

I listened for what each student said as well as what the student did not say. Rubin and Rubin (2005) state "Qualitative interviewers listen to hear the meaning of what interviewees are telling them" (p. 14). When I could not figure out the participant's meaning, I asked follow-up questions to gain clarity and accuracy. I listened more attentively than I might have in a normal conversation, respected what the participants were telling me, was sensitive to the participants' potential struggle in expressing self, acknowledged what I did not understand, and was inquisitive, yet respectful, when asking what was not yet known (Rubin & Rubin, 2005). I have many years' experience as a co-ordinator facilitating academic advising and counselling interviews with nursing students and other health care professionals. These opportunities helped me develop confidence and competence in building trusting relationships and communication savvy. This skilfulness was an asset during the interviews and the focus group interview.

Focus groups are used to gather data, and provide insight, into the attitudes, perceptions, and opinions of participants regarding nursing students connecting with their patients (Krueger, 1994). These types of groups usually take place in a natural environment, make use of open-ended questions, and the participants are influencing and being influenced by others to respond to questions and comments providing for much richer, and deeper data (Krueger, 1994). The major advantage of this type of interview was to provide a forum for dialogue and to garner perspectives on a topic of interest with a group of

participants interacting in one place and time. The focus group was comprised of seven clinical nursing faculty who had common interests and who spoke to and responded to questions regarding nursing students connecting with their patients (Kreuger, 1994; Morgan, 1998; Stewart & Shamdasani, 1990). The participants in the focus group created the dialogue and through the process of interactional exchange stimulated thinking and responses from each other (Kreuger, 1994). In doing so, participants also clarified their own thoughts and behaviours regarding the topic of interest. A nonthreatening , friendly environment, encouraged group cohesiveness and a sense of community thereby allowing participants to freely express themselves. I gained insight into the scope of perceptions expressed by the participants and was able to anticipate comments that led to a response or not (Kreuger, 1994).

I facilitate the focus group interview with an assistant moderator (a PhD student) (Kreuger, 1994). Attributes of the moderator have a direct impact on the nature of the group interaction and the quality of the dialogue. I maintained a friendly manner and a sense of humour. In addition, having knowledge of the topic helped keep the comments in perspective and allowed me to intervene and follow up on critical areas of concern. I exercised self-discipline to avoid sharing personal opinions, and thus avoided jeopardizing the focus group. I recognised that I was not completely neutral.

A team approach to moderating had many advantages. My role as moderator was to capture key ideas for future questions, and not grasp the total interview (Kreuger, 1994; Morgan 1998). I explained the procedure and

responsibilities to the assistant moderator: seating arrangements, speaker identification, and group process and dynamics. The assistant moderator operated the recording equipment, took comprehensive notes, captured participants' body language, and generally handled all environmental concerns such as interruptions. The assistant moderator with a second pair of eyes and ears was invaluable in helping to accumulate additional information (verbal and nonverbal) and the validity of the analysis (Kreuger, 1994; Morgan, 1998). The assistant moderator signed a confidentiality form.

Questions are the nucleus of a focus group interview (Kreuger, 1998). Usually there are about a dozen questions, and they must be carefully selected and sequenced to establish a logical flow. A number of different questions were used, each having a distinct purpose (Appendix S). Types of questions included: an opening question designed to be answered in 10 to 20 seconds, introductory questions designed to introduce the topic and start people thinking by fostering interaction within the group, transition and key questions that moved the conversation into the crucial questions that directed the study, and ending questions that created closure. There were three components to the ending (Kreuger, 1994, 1998b): an "all things considered" question, a summary question, and a final question "Have we missed anything?"

Interview Process and Protocol

I arranged, by telephone, to meet with each nursing student participant at a mutually agreeable time in a designated area in the Faculty of Nursing. I explained the process of the interview and had the student sign the Consent to

Participate form (Appendix L). I informed the participants that the information they shared with me would become part of a larger aggregate database. I provided a bottle of water and an apple as refreshments.

At the beginning of the interview (Appendix M), I asked the participants to think of a time when they felt that they really connected with a patient. I followed up with a question asking them to describe the situation and how and why it was the same or different from other patient situations. I also asked the participants to describe a situation when they felt that they did not connect with a patient, what that felt like and what they thought contributed to the non-connection. The entire one hour session was audio-taped. At the end of the interview, the tape recorder was turned off to allow the participant to debrief about the interview and the information they had shared. At the time I confirmed that the participants wanted their information to become part of the study and ensured that they wanted to continue in the study. I asked the participants to complete a demographic form (Appendix N) and asked them to choose a pseudonym that I would use to protect their identity during the dissemination of the research. I sent the participants a summary of their individual interview (by e-mail) for confirmation, and invited a response by e-mail or by telephone. Later I sent information about the emerging theory for their reaction and response. A few students provided brief comments, such as, “looks good”, “nothing to add”.

Immediately after each interview, I took some time to record field notes and journal (Appendix O) (Glaser, 1992; Montgomery & Bailey, 2007). I recorded descriptive and interpretive notes, that is, the location of the interview,

who was present, unrecorded nonverbal and verbal information, the context, my impressions and analysis, ideas to explore for successive interviews, and procedural decisions. The field notes were used for further analysis, to provide richness and depth to the audio taped interview data, and as an audit trail for the trajectory of this study thereby adding credibility to the emerging theory (Glaser & Strauss, 1967).

I used a transcriptionist to transcribe verbatim the interviews and the focus group interview. I explained the procedure and negotiated timeframes and delivery for the audio tapes to be received by the transcriptionist and the time and mode to retrieve the original audio tape and the transcriptions of the tapes. I had the transcriptionist sign a confidentiality form.

I journalled about my personal experience, thoughts, feelings, preconceived notions, stress, reaction to participants' responses, and the research experience itself. This allowed me to reflect on the research experience separate from the data collection experience. Field notes and journaling became part of the data that informed the emerging theory. Prior to the next student interview, I reviewed and took into account data from the interviews, field notes and journaling to determine where I needed further elaboration or explanation.

The second approach was conducting a focus group with clinical nursing faculty. I contacted each clinical nursing faculty who responded to my request for participation in a focus group by telephone/e-mail within 48 hours. I provided the participants with a Letter of Invitation to the Focus Group (Appendix P) by e-mail that included the date, the time, and the room number in the Nursing

Undergraduate Teaching area in the Faculty of Nursing for the focus group interview session. I contacted the participants by e-mail 24 hours prior to the focus group meeting to remind them of the meeting the next day, and confirmed the time, place, and room number. I also encouraged the participants to arrive a few minutes early.

At the beginning of the focus group interview I shared that the session would be audio taped and that I would be taking notes during the session. I explained the process and obtained their Consent to Participate form (Appendix Q) and the Confidentiality Form (Appendix R) for the focus group session. This was also an opportunity for friendly dialogue to establish rapport before the focus group began. I also invited the clinical nursing faculty to share in the provided refreshments. I then turned on the tape recorder and began the session. By conducting my own focus group session, I created and developed a more personable, trusting, and interactive relationship with the participants. Moreover, direct contact with the participants allowed me to pay attention to cues and non-verbal communications of the participants. These cues and non-verbal communications within context, captured as well by the assistant moderator, added a richer interpretation of the data beyond that of the spoken word.

At this point, I began the focus group interview. I greeted the participants, welcomed them to the session, and thanked them for taking the time to join our discussion on nursing student-patient connection. I introduced myself (Appendix S) and explained the purpose of the interview. Also, I informed them that I live in Ontario and that I am a Nursing Professor in an undergraduate nursing program in

a large urban centre. I introduced the assistant moderator indicating that she was a graduate student, and explained her role in the focus group. I told them that I wanted to learn more about what clinical nursing faculty observe when nursing students are connecting with their patients. I told them that I have invited people who were currently teaching in the senior medical-surgical course to share their perceptions and ideas. I also let them know that the participants in this discussion have certain things in common that are of particular interest to me. All participants were clinical nursing faculty and had taught or were currently teaching the same nursing course. I let them know that I was particularly interested in their views because other nursing faculty may have similar views. I shared some common ground rules (Appendix S) and indicated that there were no right or wrong answers. I encouraged them to share their points of view even if it differed from what others had say. I let them know the session would last about 60 minutes.

I started with an introductory question. I had name cards on the table in front of each participant to help remember each other's names. Starting at one end of the table, each participant introduced herself and shared how many times she taught this course. This was a non-threatening way to get the interaction started. The interview proceeded with the opening statement: "I want you to think of a time in the past when you felt your students connected with the patients." I told them that the discussion was guided by a series of questions that were broadly related to the statement. I paused for 2 minutes then proceeded with the next series of questions. Examples of the questions were: "What do you see or look for

when observing the student with a patient?", "How do you identify 'connection'?", and "What do you think are the qualities of connection?" A complete list of the interview questions are included in Appendix S.

At the end of the focus group, I shared a brief summary of the discussion and asked for confirmation, amendments, or corrections. The tape recorder was then turned off to allow the participants to debrief about the focus group and the information that was shared. Then I asked: "Have we missed anything?" to allow participants who may not have wanted or did not feel at ease to speak with the recording equipment on to share their opinion. One clinical nursing faculty approached me privately to discuss her approach when connecting with her students. I also reiterated at this time that what was shared in the focus group session was not to be shared outside the focus group session. I asked the participants again if they agreed to have their information included in the study and if they wished to continue in the study. All the clinical nursing faculty wished to stay in the study. I also asked each participant to choose a pseudonym that I could use to protect their identity during the dissemination of the findings. I shared with the participants that the information they shared would become one part of the data source for the study. I sent the clinical nursing faculty a copy of the focus group transcript. One nursing faculty provided clarification for grammatical and spelling edits in the transcript.

Immediately after the focus group, I took some time to record field notes and journal (Appendix O) (Glaser, 1992; Montgomery & Bailey, 2007). I recorded descriptive and interpretive notes, that is, the location of the focus group,

who was present, unrecorded nonverbal and verbal information, the context, my impressions and analysis, ideas to explore for successive interviews, and procedural decisions. I incorporated the assistant moderator's notes into my notes. The field notes were used for further analysis and to provide richness and depth to the to the audio taped focus group data. In addition, the data from the focus group, student interviews, field notes and journaling provided an audit trail for the trajectory of this study thereby adding credibility to the emerging theory (Glaser & Strauss, 1967). I also commenced journaling immediately after the focus group to write about my personal experience, thoughts, feelings, preconceived notions, stress, reaction to participants' responses, and the research experience itself. This allowed me to reflect on the research experience apart from the data collection experience. Field notes and journaling became part of the data that informed the emerging theory. In order to elicit the participants' responses to my summary of the focus group analysis, I e-mailed each participant an aggregate summary to confirm and/or clarify the information. Data collection concluded when I sent a summary of the emerging theory to the focus group participants for comment.

Analysis

The tenets proposed by the Glaserian method guided the analysis for this study, specifically, constant comparative analysis and theoretical sensitivity (Glaser, 1995; Walker & Myrick, 2006). "Using the constant comparative method, the researcher aims, through interpretation, to conceptualize the data" (Glaser, 1995, p. 469). Analysis began with the first data recorded transcript and continued with interview data in an iterative fashion throughout the study. As I

listened to each audio recording of each interview and reviewed each transcript, I recorded my initial analytical ideas directly on the transcript. This gave me the opportunity to add other information such as nonverbal data and information that may not have been picked up by the transcriptionist. These additions provided me with as complete a transcript as possible and the foundation for further analysis to occur including open coding, selective coding, theoretical coding and memoing.

Open Coding

Analysis commenced with open coding (Glaser, 1978, 1992). The purpose of open coding is "to generate an emergent set of categories and their properties which fit, work and are relevant for integrating into a theory" (Glaser, 1978, p. 56). Transcripts were examined word by word, line by line, coding for everything (Glaser, 1998). I went back and highlighted words, phrases or sentences, comparing data that caught my interest. This process is known as breaking down data into incidences through constant comparative analysis. I compared and contrasted incident to incident, and at the same time was cognizant of the neutral question "What category or property of a category does this occurrence suggest?" (Glaser, 1992) (Appendix T). As a category or its property emerged, the concept was compared to the next incident (Glaser, 1998). This process had four functions: to verify the concept as a category indicating a pattern in the data; to verify the fit of the category classification to the pattern; to generate properties of the category; and to saturate the category and its properties (Glaser, 1998, p. 139). Coding line by line discouraged me from using extant theory or personal opinions about the data, thereby staying focused on the participants' perceptions and

reality. I anticipated that in any given segment of data there could be much diversity necessitating the need for appending many code labels. I constantly compared open codes with data, compared codes from other interviews with the current participant [member checks] (Creswell, 1998). The constant comparison process helped create and highlight regularity in the data and the changing conditions associated with that regularity, produced new properties of concepts and more suppositions about what was occurring in the data. This assured the optimum selection and fit of concepts and suppositions regarding those concepts to generate a theory that fits, works, and is relevant (Glaser, 1978, 1998). As coding continued, codes were grouped together into categories that became more generalized and abstract. As the codes became more abstract, they aided the theory to become more generalized, implicit, and applicable. They also helped to associate extant knowledge with the emerging theory. Codes have two classifications: *in vivo* codes and implied codes (Glaser, 1978, 1998). *In vivo* codes evolved from the participants' own words. Implied codes came directly from the data in the study. As I interpreted the participants' experiences and integrated them into higher levels of abstraction, the language of the *in vivo* codes changed. A strength of grounded theory is that the abstract codes embodied participants' perspectives, my knowledge and insight, and extant knowledge that was important to the field of inquiry.

I asked myself neutral questions in order to keep my focus. For example, an important question was: "What is this data a study of?" To establish relevance and seek out codes that might be related, I constantly asked myself: "What

category or what property of what category does this incident indicate?" Another key question was: "What is the basic social psychological concern of the study participants?" These questions assisted me in keeping my focus and in helping guide the direction of the study.

Selective Coding

The final stage of analysis is the creation of a substantive theory (Fassinger, 2005). At this point, I ceased open coding and began selective coding. In selective coding, the work of open coding is delimited and decreased (Glaser, 1978, 1998) to focus on the core category and process. Through further data collection, analyses, dialogue with my committee members and researchers in grounded theory method, and reading extensively, I found that the core category reciprocal exchange I selected did not capture adequately the perspectives and actions of my study participants. In addition, I theoretically sampled for negative cases whose experiences did not confirm the suppositions and refuted the emerging theory. This challenged me to develop a fuller appreciation at a "higher level of abstraction of the phenomena" (Schreiber & Stern, 2001, p. 79). I continued the iterative process of data collection and analyses, dialogue and reading until such time as I identified a central or core category (mutuality) that integrated all the other categories into an explanation of all the categories combined. In addition, this core category captured the variation of perspectives and actions of my participants. The core category became the focus and I continued to theoretically sample for additional data (Glaser 1992). "Codes, memos and integration start occurring in relationship to the core

variable" (Glaser, 1992, p. 75). I wrote a brief 'core' account of the most salient aspects of the data, taking into consideration all the other categories, and expressed their relationship to the core account (Fassinger, 2005). I constantly compared the emerging theory to data to ensure the theory was grounded in the participants' experience. At the same time, I reviewed the extant literature to deepen comprehension and explanatory capability, and in addition to support and refute evidence (Fassinger, 2005). I looked for concepts and theoretical codes to emerge from the data (induction). I theoretically sampled for more data to build on or elaborate on lean categories.

Theoretical Coding

Theoretical coding identifies properties and the scope of concepts, codes and categories, and theorizes "how substantive codes relate to one another" (Glaser, 1978, p. 55). In addition, my realistic pattern requires the "internal integration of connections among a great many categories" (Glaser, 1978, p. 116). As categories emerged in the study, certain codes related more clearly to one category than another, also known as theoretical coding. I began to see the number and character of the categories and codes. As I reviewed more data, the properties and scope of the codes and categories became clearer. The data illuminated categories that were of a higher abstraction, that is, more abstract concepts. Moreover, I found that some categories could be folded into or combined with other more abstract concepts.

I am aware of the discussions in the literature regarding the selection of pre-existing concepts. There were a number of advantages and disadvantages in

abstracting to selecting pre-existing concepts. One advantage in relating emerging concepts to other study findings was that it boosted my developing confidence in analysis as a new researcher to grounded theory, rather than getting 'bogged' down in data (Fassinger, 2005; Morse, 1994), as the analysis process was extremely time consuming and demanded deep reflection (theoretical sensitivity). Reflecting on other theoretical developments helped me center my attention on the scope of the analytical process and also helped me keep focused on the inquiry. Another advantage of abstracting to pre-existing concepts was that I could enhance knowledge development by bringing together emerging knowledge and extant knowledge about my topic. This also established consistency and richness among theoretical concepts (Morse, 1994). One disadvantage of using pre-existing concepts is that I could bring to this work my own knowledge and interpretation of the concepts, thus potentially misinterpreting the meaning of the concepts as they emerged from the data. By selecting pre-existing concepts, I could be tempted to 'force' the research data and analyses to 'fit' into these concepts (Glaser, 1978).

A number of strategies minimized the disadvantages noted above. Pre-existing concepts provided a perspective only, that is, they did not emerge from my research data. I was able to ensure then that the data drove the theorizing and abstraction of the analysis, and that the concepts were identified after my initial analysis was completed. The research analysis was continually confirmed to establish accurate interpretation of the data. Pre-existing concepts could not be confirmed with participants in my study. I verified my analyses after each

interview and provided the participants with a summary. In this way, the participants were able to provide information as to the accuracy of the interpretation of the data analyses. An important point for me to keep in mind here was to remember that imposing any ‘structure’ on theorizing inhibits the theory from emerging from the data (Glaser, 1992).

As the theory emerged, I revisited the data and continued to theoretically sample asking more and more direct questions of myself and the participants. This process allowed me to make clearer the properties of emerging categories and their relationships. When further data collection did not reveal any new information pertinent to the emerging categories and their relationships, data saturation of the categories had occurred.

I returned to the memos I began in open coding and started theoretical sorting, that is, I looked for ‘connections’ or relationships between categories and properties. Since my memos were theoretically ordered, this integration was relatively straight forward. In turn, I wrote more memos adding to and maintaining a higher conceptual level. I was constantly aware that I was sorting ideas, and not data. At this point, I also integrated relevant literature (Glaser, 1992; Heath, 2006). The result was a dense, complex theory (Glaser, 1978).

In summary, I moved back and forth between data collection and analysis using the ‘constant comparative analysis’ technique. This process allowed me to keep my focus, and methodically check the data and the ‘fit’ of the data (Glaser, 1992, Schreiber & Stern, 2001). Reliability and validity were assured when I continuously monitored and confirmed my conceptual analysis and interpretation.

Memoing

Memo writing (Appendix U) offered me a vehicle to express my interpretive and constructive thoughts about the emerging theory, for example, my hunches, ideas, assumptions, queries, biases, insights, feelings and decisions (Fassinger, 2005; Glaser, 1978/1992; Montgomery & Bailey, 2007; Schreiber & Stern, 2001). Memos were a valuable part of the data and were incorporated into the analysis and generation of the theory (Glaser, 1978).

I began memoing when I first started to code the data. I inserted these memos at significant intervals in interview transcript data. My memoing accomplished the following. First, it encouraged me to question my assumptions about particular ideas, for example, connection. Second, I documented themes and patterns, that is data that was significant to nursing student-patient connection. Third, I speculated about what was in the categories, how they were linked or not, and what sampling I needed to consider to enhance the properties and relationships. Fourth, the memos helped me link the emerging theory with extant theory. Fifth, the memos stimulated upstream thinking for research ideas and strategies to share the findings from this study. Sixth and last, memoing produced an audit trail that was easily accessed to substantiate any questions, change or decisions made during the course of the emerging theory. Auditing took place throughout the study. I identified my expectations and biases at the outset of the study, had my research supervisors check and question my codes, categories, properties and theorizing. In addition, my supervisors monitored my overall

process and product to make certain I had conducted my inquiry in accordance with the tenets of Glaserian grounded theory method.

Grounded Theory Strategies to Ensure Rigour

Grounded theory studies must meet four criteria in order to ensure rigour. The theory must fit, work, be relevant, and be modifiable (Glaser, 1978, 1992). The first criteria of rigour for grounded theory studies is that the theory generated must fit the data. The categories and their properties did fit the entities being studied from the perspective of the participants, practitioners, and researchers in this area (Glaser, 1992). There were several ways in which fit was confirmed in this study. I ensured that during analysis categories were generated directly from the data. I did word by word, phrase by phrase, and line by line coding to generate categories. Some codes were named using the participant's own words. By doing this, I was ensuring that the findings correctly expressed the participant's reality. The findings were confirmed by the study participants after each interview, comments they provided about their transcript, and at the end of the study.

The second criteria for rigour that the theory generates is that it should 'work'. In sorting out the main concerns of the participants, the theory elicited the main differences in activities. A theory that works should be able to explain what is going on, what might happen, and what did happen in a substantive area (Glaser, 1978). Therefore, for the theory to work, there must be a fit with the categories, and it must "work" the core of what is happening or what is relevant to the substantive area. The theory that works must "get the facts" (Glaser, 1978, p. 4) of what is taking place, and be "relevant to the action of the area" (p. 5).

I used several strategies to develop a theory that works and is relevant to the nursing students and patients. When I met with the study participants, I developed an association and trust that aided in a more open and thorough interpretation of the data. By establishing trust, I was able to "get at the facts" of what was happening. During the interviews, I was able to reach a level of understanding of the extent of the study participants' perspectives. For example, I asked "Can you tell me a bit more about that?" I continuously revised and developed ideas to account for all known cases in the study. I looked for similarities and also for negative cases that show a difference or variation. During the interviews, for example, I asked "Have there been times when you did not feel that sense of connection with your patients? Can you tell me a bit more about that experience." I created a theory that works by reviewing relevant literature, and discussing the emerging theory with my study participants and research supervisors.

The third criteria for rigour is relevance. If a theory fits and works, then relevance is met (Glaser, 1992). By allowing core issues and processes to emerge from the data, I achieved relevance. In addition, the theory emerged from the data, and I confirmed the fit and work of the emerging theory with the study participants and my research supervisors. In this way, the theory met the criteria of relevance. I created a theory that makes clear the major variations and actions and that "gets at the facts", for all intents and purposes, a theory that works.

The fourth criteria for rigour ensures that the theory is modifiable. As new concepts and data appear, the theory must be ready to accommodate this

integration (Glaser, 1992). I was open minded to new and emerging concepts during the interviews and as I analyzed the data. To help with this process, I formulated open ended research questions to begin the research process. I also created reiterative open-ended questions for use during data collection to assist participants to expand on their thoughts and until no new information was forthcoming. In addition, I honoured study participants' perspectives; I discussed with the participants and my research supervisors the concepts and ideas emerging from the data. At the same time, I read extensively to increase my perspective regarding the concepts and ideas that were emerging from the data. I also conscientiously created memos that challenged my thoughts. In this way, the memos served as data that I entered into my thinking and theorizing. Moreover, I developed a theory that is modifiable and continuously open to new ideas and concepts.

Four interpretive criteria for rigour, based on Miles and Huberman (1994) and Lincoln and Guba (2000), are confirmabilty, dependability (auditability), credibility (internal consistency), and transferability. Regarding confirmability, the findings represented the situation being researched (as much as humanly possible). For example, the transcripts of the interviews were e-mailed to the participants for confirmation, and they were encouraged to edit the documents and return the edited work to me. An overview of the emerging theory was shared with the last six participants for confirmability. A summary of the theory was sent to participants for confirmabilty. An audit trail was established and maintained throughout the study, thus making explicit the process through which the findings

were derived. All parts of the theory fit together and they could explain the data. These were shared with my supervisors at periodic intervals throughout the study. Constant comparative analysis was used to constantly compare between theoretical constructs and new data, thus ensuring research credibility and confirmability. A thorough description of data collection and analysis was described earlier in this chapter (e.g. open coding).

In summary, by undertaking the various strategies reported in this chapter, I attained scientific rigour by creating a grounded theory that fit, worked, was relevant, and modifiable.

CHAPTER IV

FINDINGS AND DISCUSSION

This study was a most rewarding research activity. While the purpose was to examine the process 4th year nursing students used to connect with patients, by its very nature this study also afforded me an intimate view into the real world of student-patient connection as it takes place in today's nursing practice environment. I had the privilege of interacting with 4th year nursing students and clinical nursing faculty during a period of pandemonium occurring within the health care environment in Alberta, to listen to the students and faculty celebrations, concerns and frustrations, to share in their feelings of anxiety as they contemplated their future, encouraging them to focus on their achievements, and to continue to be optimistic about the future.

In this chapter, I will discuss the current health care environment at the time of this study and its impact on the participants. I will elaborate on the process of connection. The following components were found to be inherent in this process: an expectation, harder to acknowledge difficulties, spending time, building relationships, always connected, disconnection, self-assessment and reflection. The students felt that it was an expectation to connect with their patients. They commented that it was hard for them to acknowledge difficulties when they knew they were expected to connect with patients and establish relationships. The students described spending time in the context of whether they were on a surgical or medical unit, the complexity of assignments, and the availability of resources. They described three different types of relationships:

therapeutic nurse-patient relationships, social relationships, and professional relationships. Some students indicated that they always connected with their patients. Clinical nursing faculty and students described each of the three relationships indicated above differently. Self-assessment and reflection were not found to be prominent in the data.

The core concept of connection that emerged was mutuality. Inherent in this concept were three components: initial interaction, reciprocity and emotional investment. The main themes of initial interaction were ‘being a student’ and ‘student-faculty context’. ‘Readiness for reciprocity’ and ‘encouraging reciprocity’ were subsumed in reciprocity. The three themes within ‘encouraging reciprocity’ were: student-faculty reciprocity, tutors as role models, and missed opportunities. Emotional investment included four themes: getting to know patients, specialness of being a student, student-faculty context, and sometimes a struggle. I will begin with describing the health care environment context.

It is important to consider the sociopolitical aspects of the health care environment context of which the participants of this study were a part. In March 2009, the College and Association of Registered Nurses of Alberta (CARNA) reported a shortage of 1483 nurses in the province, with a projected shortage of 6000 nurses by 2016 (CARNA, 2009a). In the first quarter of 2009, no vacant registered nurse positions were filled with registered nurses. Instead, these positions were being replaced by less qualified personnel. Moreover, two-thirds of the 2009 nurse graduates could not find jobs within the province’s Health Services. According to CARNA, nursing graduates were being actively recruited

by other provinces and the United States. Of note, the province's nurse graduates tend not to migrate out of the province for work. The province's economy attracts nurses to the province frequently through job opportunities for members of their families, for example employment in the oil patch.

In September of 2009, the United Nurses of Alberta (UNA) filed a Code of Conduct complaint against the Chief Executive Officer (CEO) of the province's Health Services (Sustrik & Craik, 2009). The document highlighted the CEO misrepresenting the profession of registered nurses, and told mistruths about the plans for health care restructuring (CARNA, 2009b; Craik & Sustrik, 2009; Inions, 2009). For example, the CEO shared with nursing leaders that layoffs would only be considered as a last resort when in fact he had already announced that layoffs would occur, and layoff notices were issued the same week. It is interesting to note that prior to the action of the UNA, a warning was issued from the province's Health Services whereby nurses could not voice their opinions for fear of reprisal of job loss and unpleasant working conditions. This created an environment that negatively impacted morale and hindered nurses' ability to perform their roles and responsibilities such as coaching and mentoring of nursing students.

At the same time, the Health and Wellness Minister announced that the province "does not have a nursing shortage" (CARNA, 2009 a&b; Sinnema, 2009). In October 2009, the AHS CEO announced that "nursing's future is not in nursing's hands." He stated that "over the next 12 to 18 months this province's Health Services intends to hire less than 40% of nursing graduates, lay off RN's,

and offer voluntary retirement" (S. Duckett, speech to Faculty of Nursing, October 2009).

Hiring less than 40% of nursing graduates projected for December 2009 was a significant disappointment for fourth year students who would graduate within six months. A number of the participants talked about the uncertainty of job prospects when they graduated, being upset that they may not be able to stay in their hometown to 'nurse', and having to think about moving out of province and away from family, to earn money to pay down their student loans. As noted earlier, the participants were 21 - 23 years old. These participants represent the cusp of Generation X and Generation Y (Millenials), 1965 to 1980 and 1980 and beyond respectively. A common characteristic of Generation X is asceticism, and for Generation Y is the notion of family centricity (Cogin, 2012). Some participants lived in small towns surrounding the large city and commuted on a daily basis. Other participants commuted to the larger city for the school year. Students relied on family support, indicating it was important for them to be able to continue their education.

Students enrolled in the third and fourth year of the nursing program could be hired within the province's Health Services as Undergraduate Nursing Employees. Many students relied on these jobs as a full-time source of income outside the academic school year, for example summer vacation periods, and as casual income during the academic year. In addition, students working in this category accrued seniority with their respective union. As noted earlier, 59% of the participants in this study worked as Undergraduate Nursing Employees.

Among the first to receive notice and perhaps the most vulnerable population were the Undergraduate Nursing Employees.

In the final semester of the undergraduate program, students work full-time hours with preceptors in clinical settings. Therefore there is little opportunity to engage in meaningful employment to accrue funds. Over the course of the program students incur a significant debt load. The layoff notice had a significant impact on the students. Just six months prior, the students felt they would have a job at graduation, and many students (59%) were assured of at least some seniority within the job market. Many students expressed concern about their future and their chances of gaining employment in their chosen field. Larisa commented that, “I hope I have a job when I finish clinical.”

At the same time as the layoff notice, a second initiative was underway to recruit students for the study. In light of all the events and discontent in the health care sector, 26 students or 29% of the second cohort were recruited into the study, almost twice as many as the first recruitment drive. For some students, this was an opportunity to share their stories and to debrief, like an opportunity to vent. Burgandy described it this way: “it’s almost therapeutic to talk about our experience because no one really asks what goes on in clinical so… there you go – another golden thing.”

While interviewing these students and clinical nursing faculty, I found myself on more than one occasion thinking, “wow, what a compassionate, committed, spirited group of folks.” Casey expressed that,

> "…the patients that stick out in my mind are those patients that were maybe just a little bit challenging or it took a while to build that relationship or maybe it happened right away and you had numerous moments with them where you felt the connection, but the the rest of my life so…it's…it's a nice thing…I love nursing [laughs]. It's a very…it's a privilege to be part of these people's lives…I feel as though I'm…touching all of society kind of thing, like I …meet so many different people from all walks of life, in all stages of life. It just is very …rewarding and I feel like I have a greater view of the world because of it."

Process of Connection

Students and clinical nursing faculty facilitated my understanding in coming to know the inherent processes and outcomes if connection does occur. Key themes that emerged from the data will be discussed here. Students and clinical nursing faculty indicated that connection may or may not happen right away. Connection could potentially be a momentary or long term event. Both students and clinical nursing faculty indicated that spending more time with the patients increased the likelihood of a good connection and supported the development of trust. Most students agreed that it was not always easy connecting with patients. They found it hard to acknowledge difficulties connecting since they knew it was an expectation of their role as a student. A few students indicated that they had a connection with all their patients.

Students and clinical nursing faculty indicated that connection may or may not happen right away. Perhaps it is the degree of refinement of communication skills that play an important part in whether it takes a few moments or a few interactions for a connection to take place, and whether it is a good connection or not. Herman described it this way, “I think you can have a connection with any of your patients and …not a relationship with them or vice-versa…I think connected more like a momentary thing whereas a relationship would be more ongoing.”

An Expectation

Parse (2010) wrote that, “Solemn regard for human presence is holding dear that precious gift of humanness with devout acknowledgement of unique” (p. 258). Students understood that it was an expectation to bear witness with others [connecting] and at the same time separate with speech, silence, movement and stillness (Parse). Susan described it this way,

> “like it’s a personality trait if you can … connect with someone and…be that kind of person but I think also [in] nursing you gotta force yourself to develop that connection or relationship with your patient because you’re providing all their care or you’re – they’re dependent on you for the whole shift or the duration of their hospital stay.”

“The development of a helping-trusting relationship between the nurse and the patient is crucial for trans-personal caring” (Jesse, 2010, p. 95). Suzy commented that, “I think…connecting with a person is pretty valuable at first to…help develop the trust.” Students also recognized that the connection was necessary to build relationships. Casey suggested that, “I’d say a connection leads

to a further relationship. You have a professional relationship with your patients no matter what, I guess, but the connection deepens that relationship and maybe …makes the patient feel more comfortable with you." Bill said "Yeah, I think it starts with a connection then moves on to [a] relationship." Some students described having difficulty gaining the trust of family members as influencing their connections. Casey described it this way,

> "…I was on a medicine unit and this patient had actually recently been classified as palliative. She wasn't…really…conscious a lot of the time because she was medicated so heavily because she was in so much pain but her husband…wasn't very receptive to a student and I understand that is was a reaction to the fact that his wife – that he had just been informed that his wife – there was nothing that they could really do to help her and it was a reaction of grief and he just wanted the best care possible for his wife and I completely understood it but it was also a little bit unfortunate because I also feel that given the opportunity I probably would have rose to the occasion…uh but in the end it's the patient's comfort and there so I stepped back and let the staff take care of it."

Harder to Acknowledge Difficulties

Students found it harder to acknowledge difficulties connecting since they knew it was an expectation of their role as a student. They were aware of their responsibility and accountability in developing connections with their patients and also their respect for space and privacy (CNA, 2008; CNO, 2008, 2009). Kathy explained it as follows,

> "As nursing students we're told you have to build this connection with your patients - you know - this is what you have to do or this is what you should be doing, and it's…hard – like when it's hard and you can't develop that but now like after…having experience and stuff sometimes you just can't break that barrier and I've accepted that like not that I've given up or tired not to give the full holistic care but to – people have the right to their space and their privacy."

Brenda suggested that, "…you have to interact just to…just to get through the day …it's a big part of why I went into nursing because you do get all that interaction with someone and …the good connections are something that gets you through the day." Several students reported having difficulty in establishing connections with patients. The students described being frustrated, incompetent, feeling like they had failed, and not having completed their job. Marie described it this way,

> "…it's tough going into that room knowing that patient doesn't…isn't…willing to share everything with you. I find it difficult…and I haven't really found a specific way to get past that. I still try to provide the best care I can …it's frustrating – yeah not knowing that they don't trust you completely and that there's not really a specific way that you can earn that trust…it's frustrating going in and them just…letting you care for them physically…and not…letting you in on everything that's going on."

Jesse (2010) wrote “as nurses acknowledge their sensitivity and feelings, they become more genuine, authentic, and sensitive to others” (p. 95). Students indicated it was hard to share with colleagues when things were not going smoothly. Perhaps this is an outcome of a culture where students are not encouraged to relate their emotional side and express their perceived inadequacies. Christine indicated that,

> “There was two other males that I’m going to talk about…I felt like I didn’t WANT to go to anyone about it [difficult patients] because I knew that it was my problem that I just needed to get over this…confidence issue. I feel like confidence was the reason for it. …yeah, I needed to talk to my tutor and my peers and just be like WHA, what did I just DEAL with like how could I have done this better? I feel SO incompetent with my care, and it’s difficult sharing those situations of you know frustration and incompetence because…I find that in nursing it’s not usually just one situation that makes you feel frustrated and incompetent; it’s MANY; it’s one after the other after the other and then it just builds up but then to try and relay that to someone, it – the significance is not…you can’t share the significance because it’s very personal, it’s very internal, the ways that you’re perceiving these things, and the other person can’t perceive it the way that you…did, so it’s good to talk about but I didn’t… I didn’t feel settled after speaking with my tutor or my peers about the situation.”

Other students had difficulty describing ‘connection’. Jasmin stated “I don’t really know how you feel like when you connect with somebody you

just…get along with them or…you can …..it's almost like…like you have that nurse relationship…like don't mind like being around them." Herman suggested that connection was "harder to describe…more to do with…mm…like outside of hospital context…being able to like laugh with the patient or share something with the family." Geneva said "…just because you have a relationship with somebody doesn't mean that you're like really engaged or connected with them. You're not really…a connection to me is uh…knowing…something about the person and the other person reciprocating something back…both parties care enough to listen."

Spending Time

Students indicated that time was a factor in their ability to connect with their patients. Most students revealed that they had the time to spend with their patients and make those connections. They commented on whether or not they were able to manage the number of patients and the complexity of their patient assignment. The number of patients they were assigned and the complexity of each of the patient's case, determined whether they would have time to address more than the "tasks" for each patient. Potentially, students could be missing valuable opportunities to connect with their patients at a deeper level and to build trusting, meaningful relationships required to 'get at' what this experience means to them [patients]. Students shared the following experiences. Casey said

> "As a student I really enjoy it [being a student] because we do have that time. We don't have the full patient load that RNs actually have…but let's say I had a patient assignment of five patients they were all extremely

> heavy, then I might not have the time and therefore the connection wouldn't be made necessarily – or there wouldn't be as many opportunities to make those connections."

Herman described it this way,

> "if you have 3 or 4 patients in one shift you get kind of busy and kind of distracted in your task oriented thing versus patient-centered care and when I go in day one doing a head to toe assessment, getting them organized and a bunch of meds five and all that…that's how you kind of get distracted from really talking to your patient and seeking how they're feeling and what's going on with them and what's going on with their families and…so sometimes I might come later in the day …."

The students did comment that length of time and whether the unit was medical or surgical were factors that affected the relationship that they developed with patients. Many students on the medical unit acknowledged that they did have the time to connect since the patients were usually there for a longer period of time. Students on medical units suggested that it was dependent on what interventions the patients were receiving. Geneva indicated that, "…if you have a medicine patient that doesn't have any real interventions and it's just vitals q shift and meds then you're only in that room like…while you do vital signs and that's it." Perhaps students are not recognizing the opportunities that present themselves to connect with patients. This is a missed opportunity to glean more information about what this experience means to the patient, to integrate all aspects of the

patients' needs, to prepare for and provide individualized care, and to provide valuable teaching for the patient and the family members.

Even though there was less time to be with patients, students indicated that they could connect with patients on the surgical unit. They suggested that because of the high turnover of patients and many interventions, there was more urgency and opportunity to connect with the patients. Geneva explained

> "I guess on a surgery unit you have LESS time to build that [relationship] because there's such a high turnover…but usually if they're an acute surgery patient, post-surgery patient, they have a lot of interventions so there's a lot of opportunity for you to walk into the room and talk to them."

The availability of resources and not the length of time that they had with the patients were identified by many students as a problem. They commented on the acuity level and the availability of human resources [nurses and other health care personal] to care for patients at a higher level of acuity. The students commented on how this affected their ability to connect with patients and what care they were able to provide. Marie indicated that,

> "I found well just in general just how the healthcare system is going right now. Some days I feel like I only have time to give meds and do those physical aspects and don't have the time to connect with those patients. Yeah I - yeah I – in my experience it's not because surgery or medicine is more busy or more heavy, just depending on staffing and how busy it is that day."

Perhaps in these circumstances, students are bearing witness to a system that is "chasing its tail" to provide the immediate, necessary care for patients without the benefit of knowing what the full experience means to the patient, and the patients ongoing well-being (Turkel &Ray, 2010). Are they role modelling the behaviours of nurses who are meeting only the physical needs of the patient in an effort to "get through the day"? In my opinion, patient safety is a huge concern here. If only the physical needs are being met, what are the other psychological factors that perhaps are contributing to and perpetuating the physical signs and symptoms? Does the student recognize what aspect of care they are not attending to and how the psychological, spiritual aspect of care is often fundamental to physical healing? Do they understand what holistic, patient centered care means (RNAO, 2006)?

The number of patients and the complexity of the patient assignment were situations that some students indicated created a more stressful working environment. They commented that this stress hindered their ability to be open and therapeutic and consequently connect in a meaningful way with patients. Nova indicated that,

> "you can't not give care to people and that REALLY takes away the time that you have to take that little extra time to get to know people if you're so focused on trying to get all your care done because you don't have any time then that really cuts down on that therapeutic relationship." She also suggested "As a student and also as a staff nurse I think the stress increases which decreases your ability to be open and therapeutic."

Perhaps there is a need to look more carefully at the assignment of patients to students. Is the patient assignment meeting the needs of the students? Is it student focused and conducive to a reasonable teaching learning experience? Perhaps the assignment is being based on the acuity of patients and available human resources to look after that level of acuity. Is the assignment providing the student with the opportunity to develop praxis, and thus supporting the needs of the student in a teaching learning milieu?

Many students commented on how they felt when they could not connect or had difficulty connecting with patients. There are a number of aspects to this. The clinical nursing faculty may have wanted to challenge the student, without adequately assessing the student needs in advance. Perhaps the student was prepared for the assignment but encountered unforeseen difficulties. In any case, the students indicated that they felt frustrated because they had not done their job. They also commented on this as a missed opportunity to learn as described by Casey:

> "it was frustrating and I felt that I was robbed of an opportunity to grow as a person because since the I haven't really taken care of a patient like that and that's unfortunate because…when I graduate I could be expected to and …I want to be the best that I possibly can so that experience probably would have helped me…in the future."

A few students suggested that they did not have time to really connect. They suggested that time was a huge factor and that they needed time to build trust with others. Sally suggested that,

> "I just didn't have that time to really…connect because I really don't think anybody just meets somebody and says oh hi we're gonna be best friends…time is a huge factor in going from just interaction to…an actual…relationship because you have – you need time to build up that trust in the other person…."

Perhaps these students' role models were clinical nursing faculty and nurses who stressed the importance of doing the tasks and skills, such as the bed bath must be done before first break and vital signs before breakfast with little explanation as to why this was important or not. Perhaps the focus ought to have been on the assessment and holistic plan of care for the individual patient, in conjunction with the other patients assigned to the student, and how to connect with patients during these encounters. A missed opportunity here may have been of how to help the students organize and prioritize their time so they would see where they would have time to connect with the patients.

Building Relationships

According to Hawthorne and Yurkovich (2002) "human relations encompasses an understanding of the human condition, the meaning and purpose of life's journey – and the realization that this journey through health and illness is made not alone but with another" (p. 53). The experience of relationship becomes known in a unique and often capricious manner (Buber, 1966). Susan suggested that, "connections are the small things that come together and the way that you positively related with somebody to build a relationship with them, and relationship is more so the outcome of those connections." Students and clinical

nursing faculty struggled with trying to define what they meant by relationships. They made reference to three different types of "relationships" they experienced in the course of connecting: the nurse-patient (client) relationship, the social relationship, and the professional relationship.

The I-Thou relationship described by Buber (1957) is said to have captured the ideal of what he described as the equal partner connection, a process of mutual discovery, that nurses strive for in the nurse-patient relationship. The The goal of this relationship is to meet the needs of the patient. This relationship is dynamic, time-limited, and utilizes both cognitive and affective degrees of interaction. The Registered Nurses' Association of Ontario (2006) describes therapeutic relationships as "grounded in an interpersonal process that occurs between the nurse and the client(s)… is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client" (p. 13). The College of Nurses of Ontario (2006) describes five components of the nurse-client relationship as "trust, respect, professional intimacy, empathy and power" (p. 3). Regardless of the context, length of time and interaction with the patient, and type of care provider (e.g. primary or secondary), these components should be present (CNO). According to Hawthorne and Yurkovich (2002), "the patient-nurse relationship encompasses sameness, closeness, and connection…" (p. 53). Whereas, many students described the nurse-patient relationship as being task oriented, that is, get in and do the necessary items for that patient and go on to the next patient. Brenda stated,

> "…within nursing we learn how to create a therapeutic relationship and then to maintain it and then to …terminate it, so …I mean I went through all the steps with this patient I got to know…maintain a relationship and then when he got discharged we terminated it and everything worked out really well…."

Herman stated "I think a therapeutic relationship you can have with any of your patients, regardless of the connection." Moreover, the student indicated,

> "connection is kind of going beyond relationship to like HAVING a relationship with a patient outside of the context of your therapeutic relationship and actually…getting to know them more, getting to know the family more, helping them in a way that they didn't expect you to help in hospital…."

Some students did acknowledge the cognitive and affective dimensions within this relationship, however they did not mention the relational aspects expressed by the patients. Geneva offered, "I think of …the patient…nurse relationship, naming it like that rather than like a …a professional relationship…uh…it has a…ah…personable…tone to it I think." This student stated "I think therapeutic is…is more a little bit more…because…you're taking into account their social history too." Perhaps the students identified that going beyond the tasks, and taking a social history constituted the holistic nature of assessment and care.

Other students described a social relationship that had its beginnings in their social development prior to entering nursing school. They commented on a social relationship as being more of what they would experience with a boyfriend

or girlfriend, the relationship among siblings and family members, and close friends. The students did not see this as a relationship they could have with their patients. Sally commented "…a social relationship for me is to vent something or I'm frustrated with my boyfriend or something like I'll go and call up one of my girlfriends and just let loose, like I wouldn't do that on a patient at the hospital…." Suzy indicated that her "small-town roots…I just feel like small-town people you get to know them and you have to be nice and you have to be accommodating, and we were just brought up that way." Most students were aware of their need to remain within their professional boundaries (CNO, 2009). Students indicated that patients sometimes confused the notion of a social relationship and a therapeutic relationship, and the dilemma they described because of this. Brenda described it this way,

> "I think sometimes maybe my patients confuse that it's a social relationship versus a therapeutic, so I don't know that might be a fault of MINE like I don't think it is like…the areas of – topics of conversation are always appropriate it's nothing…that I would ask…that's too personal or inappropriate at all but…I don't know – maybe – they take my friendliness as…I don't know – it's just it's hard to…hard to describe I guess because…in a way it is social but it - I always remain professional I mean there's no way that…they should confuse it for anything else but I guess it's just…maybe the patient so much don't know that you know…employees especially nurses maybe shouldn't give out their last name we can't give out phone numbers that kinda thing so maybe it's

> just…patients don't know about how much nurses can give out information…."

Perhaps students are asking for more support with these kinds of patient encounters. Where does the formal education in moral and ethical reasoning fit within the curriculum (Tarlier, 2004)? How is this education reinforced in the clinical environment? When and how do clinical nursing faculty and nurses nurture this aspect of holistic care with students? Students did indicate that having developed these social relationships prior to entering nursing school helped them to further develop relationships, in that they were able to start out on common ground with patients and remain within their professional boundaries.

The professional relationship was described by a number of students as the relationship that had much more meaning and depth. Students talked about being able to engage in the pathological necessities of care and being able to encourage the patient to reveal the relational aspects of what this situation means to them: the physical and psychosocial aspects of care. Susan described it this way,

> "To me it's [develop that deeper relationship] more important. I've never been one to think that…tasks are a huge priority. I think that by the time you know - by the time I've worked for a year I'll be so good at doing all of them that they'll [tasks] just be - it'll be second nature and once you're – I mean it doesn't, it doesn't take a lot of time to, to get your skills down pat, and what are you left with after you've done that – do you just…go into rooms quietly get your things done and leave, it would be so boring."

Geneva also suggested,

> "…in terms of relationship like professional relationship there is like a duty there, right, but connection there's …in terms of professionally there is a duty there that uh…you're able to …I guess relate more to your patient in terms of what their needs are. You're able to anticipate better what their needs are then …uh…if you didn't have that connection then there'd be like kind of a barrier of you knowing well does this person want A, B or C or what would be best for them…I guess."

One student described the professional relationship differently than any type of relationship discussed thus far. She suggested that this relationship reflected an encounter she would have with patients that were not assigned to her care. Marie described it this way,

> "…there's the patients you have a professional relationship with where you'll – the patients that you go in and visit on the days where they're not maybe your assignment, or yeah those patients that when they see you in the hall they'll ask you to stop by and visit or they'll come to you with their problems and concerns on a day when you're not assigned to them."

Most students reinforced the difference between the therapeutic relationship and the professional relationship. Marie described it this way,

> "What I guess therapeutic relationship would again to back…to your question of the connection maybe, like a type of relationship where you have a connection and communication is open and then for me a professional relationship would be where you can discuss things with the

> patient that aren't maybe necessarily medical and to them maybe you can be…the confidant…for what they are going through in personal experiences without again without kinda letting your own personal like come into it and getting…too close with the patients."

Alexander added that,

> "…a relationship could just…you can have positive negative relationships, you can have all different TYPES of relationships I mean – not that ever be recommended but you can have unprofessional relationships so I think maybe a relationship is just that series of interactions and I think a connection sort of a little bit different than just a series of interactions…it seems to me that a connection would be something where there's mutual interests or there's some sort of…mutual benefit to, TO those interactions" (117-125).

This student indicated that "connections are always positive and relationships could be EITHER [positive or negative]."

Many students described the therapeutic nurse-patient relationship as that relationship whereby only the tasks are attended to. Very few students described this relationship as attending to the holistic aspect of care. The social relationship was described by most students as that relationship that one would have with friends and family, and not with patients. They did however suggest that aspects of a social relationship helped them establish relationships with their patients. The professional relationship was described by most students as that relationship that encompassed the holistic aspect of patient care.

The therapeutic nurse-patient relationship is described as providing holistic care (CNO, 2006, 2008). The students commented on professional relationships as being holistic. Are the students associating the idea of "professional care" with "nurses" being professionals? How did the introduction of the therapeutic nurse-patient relationship in year one of the program evolve into the professional relationship described by the students in year four? Perhaps the experiences students were exposed to in the classroom and the clinical environment shaped this idea of relationship.

Most clinical nursing faculty agreed there was a difference between connection and a relationship, and an interaction, but one needs strong communication skills for all aspects. Not all clinical nursing faculty were in agreement with whether having a connection lead to a relationship and vice versa. Jojo indicated, "everybody can have a relationship, but not everybody can make the connection." Gracie suggested that, "you can connect with someone just by looking at them and by smiling, but that has nothing to do with a relationship." Gracie stated "you don't need a connection to have a professional relationship," whereas, Chelsea indicated "you need a connection before you can have a therapeutic relationship." Susan [student] summed it up this way, "connections are the small things that come together and the way that you positively relate with somebody to build a relationship with them, and a relationship is more so the outcome of those connections." Renee suggested there was no difference between connection and relationship. She indicated that,

> "not really, because there is that therapeutic relationship that needs to be developed and part of that IS your connection with your patient. If you can't…like there's a nurse – nurse-client relationship and I think that's difference than a therapeutic relationship if you can have the nurse-client relationship without have a therapeutic relationship and I think therapeutic one is more connected, like more of a connection, not just like …the my way or the highway but the collaboration where we're working together towards that healthier person in a more of an – like a holistic view…where you can have a nurse-client relationship which IS being my way or the highway, we're gonna do it this way, more of a domineering type thing and I don't think that's a connection."

Clinical nursing faculty agreed that they wanted the students and the nurses to have a therapeutic relationship. Chelsea stated "I think we want our students and our nurses to have that therapeutic relationship, recognizing the whole person, not just a person who needs a dressing change." Whereas, Grace suggested that "a relationship whereby the person who needs a dressing change would be regarded as a professional relationship."

Always Connected

A few students indicated that they connected with each and every patient for whom they cared. Wallace indicated that,

> "I feel every time I go and talk to a patient that uh I'm connected with them, in empathetic manner…I feel AS connected to one patient as I do to

> another…I do not feel that I've ever not been connected with my patients… all my encounters with every patient are the same."

The students did not indicate what they meant by connection other than to say that they connected "in an empathetic manner". Perhaps these students used a mental script whereby they approached each patient the same way and asked each patient the same set of predetermined questions. Did they do the tasks only? Perhaps they did not know what they did not know. Did they have difficulty approaching new patients? Perhaps the mental script was their safety net or they were role modelling the behaviour of their co-assigned nurses. This approach does not represent "patient-centered care", meaning a focus on the individual and including significant others. This is a potential safety concern with regard to planning of care and giving patient care. What opportunities are missed when the student does not connect with the patient as an individual? What additional knowledge could be gleaned for the plan of care when the student includes the relational aspects of care? How does the student demonstrate holistic care and meet the requirements of the course and the terminal program outcomes?

Disconnection

A disconnect was found among the clinical nursing faculty about their interpretation of what might be a therapeutic and a professional relationship. How does this translate to the clinical setting and the teaching and learning of students? How do the students begin to learn and practice what is known as holistic care when this ambiguity exists surrounding the notion of relationships? Do clinical nursing faculty have different expectations of students with regard to how holistic

care [recognizing the whole person] is enacted? Perhaps the standard of assessment being used to assess or determine the preparedness of the student to move forward in the program is not fully understood by the students and the clinical nursing faculty. How do students navigate the different expectations of the same concept [therapeutic nurse-patient relationship] presented to them by clinical nursing faculty and nurses? Perhaps the students, through prior learning in the program, have learned to accommodate the idiosyncrasies of the clinical nursing faculty and nurses. Perhaps this might explain the disconnect between the students' and the clinical nursing faculty's interpretation of a therapeutic relationship.

Some students captured the struggle they encountered when trying to know how to connect and develop relationships, and this may be a symptom of the disconnect identified earlier. Using nurses as role models helped the students develop good 'habits' as described by Renee,

> "it's important that as a student to learn how to connect and that's how to teach that is I think difficult. Nobody taught me how to do it; it was from watching other nurses and you recognize you know what – that's a nurse I want to be like or…I don't want to do that, I don't like that and you start to I think that's how you form a lot of your habits …tutors can give direction, but I don't think they can…it's not something you can rehearse, [not like] IV starts you can't try over and over again."

Is the nurse regarded as a substitute for the clinical nursing faculty by the students? Perhaps what they are learning is just that, "habits", such as attending to

tasks only, thereby reinforcing the ideas of students and some clinical nursing faculty of what constitutes a therapeutic relationship. Although attending to tasks only does not encompass the full scope of practice of a registered nurse, this could potentially be interpreted by students' as normal practice for registered nurses.

Self-assessment. Baxter and Norman (2011) wrote that "self-assessment in nursing education to evaluate clinical competence and confidence requires serious reconsideration as our well-intentioned emphasis on this commonly used practice may be less than effective" (p. 2406). Students need to develop self-assessment skills to determine their level of knowledge and to identify gaps in knowledge, to remain current and safe to practice (Baxter & Norman, 2011; Brixey & Mahon, 2010; CNO, 2009). While some students in this study indicated they did engage in self-assessment, that is looking at their strengths and weaknesses, the self-assessments may have been inversely related to their clinical performance. Moreover, given that self-assessment is probably intensely context-bound, then an accurate assessment in one domain does not necessarily mean that the student is successful in all domains. This learning strategy builds confidence and may give the student a sense of increased competence. However, does it improve performance when connecting with patients? Although, some students, after completing their self-assessment, and during their context-based learning modules, pondered if they were on the right track as they reported they were learning from each other with little input from the tutor. Baxter and Norman (2011) indicated that "instruction and practice increased confidence without commensurately improving performance" (p. 2412).

Are clinical nursing faculty viewing self-assessment as a general skill? Perhaps clinical nursing faculty rely on the students' to do self-assessments and then use this information to collaborate with students to develop a plan to address their learning needs with regards to connecting with patients, and their ultimate competence to do so. Nelson (2012) comments on recent work by colleagues in medicine who published work that "raises serious concerns over the validity of self-assessment in competence assessment" (p. 204). If students are indicating that they wonder if they are on the right track, and clinical nursing faculty are using the students' self-assessments as the main teaching strategy to determine learning needs without further inquiry, I see a potential here where the important aspects of student needs, and unidentified needs when trying to connect with patients, may not be addressed and acted upon. Nelson (2012) further explains that with self-assessment "researchers bring evidence to bear that seriously challenges the empirical basis of self-assessment and thus raise questions as to the 'validity' of reflection in competence assessment per se" (p. 205).

Reflection. According to Nelson (2012), reflective practice is the process created by Schon in 1983 to describe "the cyclical interaction of learning and experience" (p. 203). Nursing introduced reflection in the 1980s as a teaching-learning strategy. However there seems to be a lack of consensus among educators regarding the nature of this concept (Hickson, 2011; Nelson, 2012). According to Raychel (2007), reflection "is a cognitive, reasoning and active process, involving internal confrontation of events, clarification of thoughts and justification of actions" (p. 28). Bulman, Lathlean and Gobbi (2011) found that

"student and teacher perceptions of reflections included critical analysis of feelings and knowledge in order to lead to new perspectives about practice" (p. e12). Reflection allows the students and the clinical nursing faculty to re-interpret meanings, explore their feelings, and identify trigger events. From this they can gain new perspectives, predict consequences of their actions, and propose enhancements. Essentially, reflection enables learning, the creation of contemporary viewpoints, and praxis (Carper, 1978; Raychel, 2007). Nelson (2012) asserts that it is "an essential component of, and perhaps even proxy for, continued education (p. 203). Described another way, "Critical self-reflection is a combination of rational thinking and subjectivity or emotion that enables the nurse to evaluate his or her own judgment, which leads to rational reconstruction" (Habermas in Sumner, 2010). Reflection skills are essential to life-long learning and development (Dekker-Groen, van der Schaaf and Stokking, 2011).

Reflecting on practice makes it possible for the students to conceptualize embodied experiences, and consequently their connection or not with patients (Ranheim, Karner, Arman, Rehnsfeldt & Bertero, 2010). Additionally, reflecting on practice makes it possible for clinical nursing faculty to revisit their experiences or not with students.

Boud, Keogh and Walker (1985) suggested that "reflection is about mindfulness and recollections of experiences, whereby people ponder, digest and appraise on them (p. 19). Delmar (2006) argued that "nurses easily become 'need oriented' at the expense of sensibility and focusing on the whole situation" (p. 241). Indeed, in this study, students frequently indicated that the focus was more

on skills and tasks than on the holistic nature of the experience. This practice reflects Bulman, Lathlean and Gobbi (2012) notion that "illustrates the influence of rationality on most participants' perceptions of reflection" (p. e12). In this situation, students and clinical nursing faculty could simply be applying theory and research in practice as opposed to using them in light of their experience through reflection (Bulman, Lathlean & Gobbi, 2012). Few students indicated that they would seek out their tutor or other students for a 'debriefing' following a reflection of a significant event. How then do students validate what they think they have learned from reflecting on the event? Do the students recognize the three stages of the process of reflection? According to Shields (1995) the three stages are: anticipating the experience and doing some mental preparation for it, being exposed to the situation and tries to integrate this with the theory and classroom work, and tries to make something of the experience. Shields argues that the final stage is the most difficult and the one that is often neglected. Do clinical nursing faculty facilitate the stages of reflection with and for the students to learn the elements of reflection? Students indicated that they could discuss events in post-conference. However, they indicated that this was not always a beneficial experience for them as the telling of the story was not within context, that is, the students were not on the same unit, were not experiencing the same nursing practices, and the tutor's focus was on many units and not just the one where the student had the experience. Do clinical nursing faculty value the holistic nature of practice and engage the students in dialogue regarding connecting with the patients? Are they able and willing to participate in the

reflective discourse with the student as speaker, listener, and observer? Can they regard the students' narrative from a detached, objective perspective? Perhaps there is an opportunity for a more facilitated approach to what the meaning of reflection is, its benefits to help students reflect on their connections or not with patients, and how to learn to reflect. Working with Year 3 medical students, Aronson, Neihaus, Hill-Sakurai, Lai and O'Sullivan (2012) demonstrated that teaching learners "the characteristics of deeper, more effective reflection and helping them to acquire the skills they need to reflect well improves their reflective ability as measured by performance on reflective exercises" (p. 807). Dekker-Groen, van der Schaaf and Stokking (2011) developed a framework of teacher competencies that might be used for curriculum development with regard to reflection skills and for teacher training programs. Tailor made coaching is an example of a reflection skill that incorporates thinking activities, for example 'structuring', during students' reflection processes.

A few students described the notion of relationship and connection differently suggesting that relationships are a series of interactions that can be positive or negative, professional or unprofessional. They described connection as more than a series of interactions and something that leads to a mutual benefit.

The process of connection then evolves through a series of events that perhaps commenced with an initial interaction. Trust developed as a result of limited or several interactions leading to relationship building for reciprocal exchange of information and sharing of ideas. In some situations, this led to embodying the physical, emotional, psychological, spiritual nature of holistic

nursing care. Many students were able to articulate the characteristics of reciprocity, but few students were able to articulate the characteristics embodying the concept of holistic care.

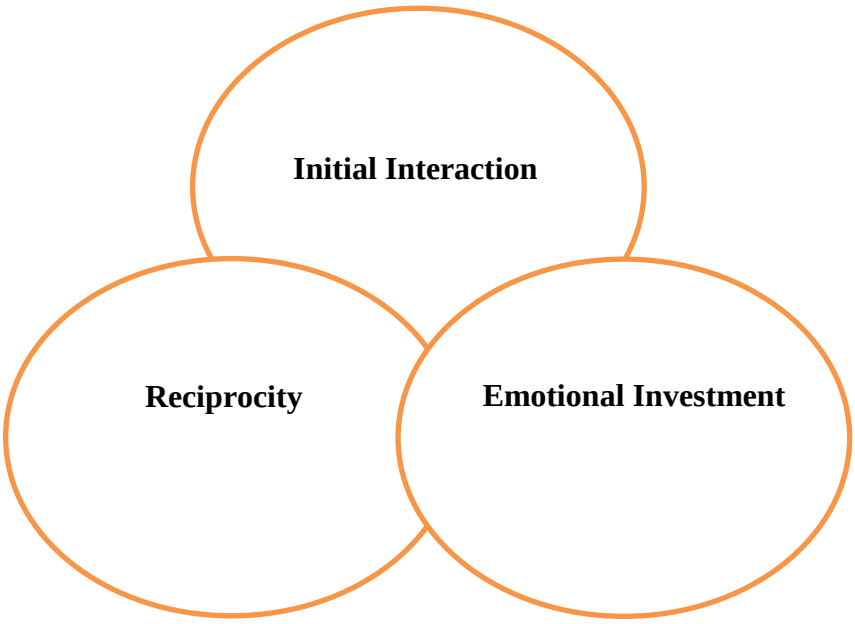
Mutuality

The core concept of connection that emerged was mutuality. Three key components found to be subsumed in the process of mutuality were: initial interaction, reciprocity, and emotional investment. These components in turn comprised several subcomponents. For example, reciprocity involved the sharing between the student and the patient, while emotional investment encompassed the deeper feelings experienced "in the moment". A schematic model of the process of mutuality is presented in Figure 1 on page 117. This model depicts the core concepts which explain how the process of mutuality is developed in the connecting experience. The findings of this research study reflect the perceptual views of two groups that include 4th year nursing students and clinical nursing faculty.

In this study, the process of developing mutuality is an interactive process in which the patients provide the students with the opportunity to build on their ability to connect with their patients in the practice setting. Fundamentally, as with any interactive process, it can be laden with many obstacles, not the least of which is the fact that the process of developing mutuality usually occurs when two people come together as strangers (Parse, 1996; Peplau, 1991).

Figure 1

The Process of Nursing Students Connecting with Patients



Within the context of a practice environment that is taxing at best and overwhelming at worst the students and patients strive to interact with one another within their professional and personal roles. They interact on a one-on-one basis for unlimited periods of time in what may be considered to be one of the most demanding set of circumstances. If the interaction proves to be promising, it becomes favourable for the student and the patient. If, on the other hand, it is less than favourable, not only is it frustrating, but it can be particularly upsetting for the student and the patient. In fact, a substandard clinical experience can result in student disenchantment about nursing and a lack of ability to assimilate and learn

(Peirce, 1991). However, if the clinical nursing faculty are genuinely committed to the role, the clinical experience becomes both beneficial to the student and gratifying for the clinical nursing faculty.

The second major component of the process of developing mutuality is reciprocity. Reciprocity is described as “the practice of exchanging things with others for mutual benefit” (Oxford University Press, 2005). Reciprocity is having a mutual affection and interest in one another (Phillips, Haase & Kooken, 2012; Miner-Williams, 2007; Waters, Cross & Runions, 2009). Buber (1957) captured the term reciprocity when he stated “Man exists anthropologically not in his isolation but in the completeness of the relation between man and man; what humanity is can be properly grasped only in vital reciprocity” (p. 111). This component may be described as that feature of the mutuality process in which the student is encouraged by the clinical nursing faculty to consider various perspectives, and to pursue alternative ways to approach patient situations for the purpose of connecting with the patient at a deeper level.

If feelings are attached to this sharing experience [reciprocity], then there is emotional investment. The third major component of the process of developing mutuality then is referred to as emotional investment; a condition whereby the physical needs and the human caring side of nursing are considered (Gallagher-Lepak & Kubsch, 2009). Watson (1999) describes a ‘transpersonal caring relationship’ as being “a special kind of human care relationship – a union with another person – high regard for the whole person and their being-in-the-world” (p. 63). Gallagher-Lepak and Kubsch (2009) state that “transpersonal caring

interventions build a deep connection with the patient through providing comfort, pain control, well-being, wholeness, and healing" (p. 171).

While there are many aspects associated with student-patient interaction in the practice setting, including professional socialization of the student, the focus of this study was to determine the process used by nursing students to connect with their patients. To discover this process, I believed it appropriate to describe 'connection' based on the perceptions of the 4th year nursing students and the clinical nursing faculty. The interpretation of the term 'connection' varied from student to student and from clinical nursing faculty to clinical nursing faculty. Although very little is written about this phenomenon, this finding seemed to parallel the variation in the perspectives of experts in the field.

Developing mutuality provides students with the requisites to genuinely engage with their patients rather than interact through superficial conversation, and to better understand their relevance in creating a mutually conducive environment within which to dialogue. Ultimately, students who develop mutuality in their practice are those students who possess the freedom to be more inquisitive, and to explore deeper feelings with the patient even when those feelings may not be readily apparent.

The process of developing mutuality, discovered in the student and clinical nursing faculty perceptions, indicates three components found in this instance to be fundamental to the process: initial interaction, reciprocity, and emotional investment.

Initial Interaction

Interaction is defined as "a mutual or reciprocal action or influence" (Merriam-Webster Dictionary, 2011). It is described as a superficial, coming together of strangers. Students often enter into an interaction with the patients without determining the boundaries but with an openness to the presence and possibility of mutuality (Berry, 1985). The interactions are described by students as being task oriented and purposive or with purpose. Tuckett (2007) suggests that interaction uncovers the subjective experience of relationships, whereas Fleischer, Berg, Zimmermann, Wuste and Behrens (2009) define interaction "as a mutual process of interpretation and construction of meaning" (p.339). Meleis (2012) states that it is the central concept in nursing, and interaction "is the major tool by which nurses' build trusting relationships" (p. 102). Since interaction has a behavioural component, then it is impossible to interact passively (Davies, 1994; Fleischer et al, 2009). Most students indicated that as they interacted more with the patients it was like "stepping stones" toward building a relationship. Sally added that "the combination of probably those interactions …then builds that trust…."

Most students encountered many different situations in which it was difficult to interact and build a relationship. They struggled with trying to build relationships with patients who exhibited cognitive impairment, for example, patients with diagnoses of Alzhiemer's disease, dementia, acute brain injury, and patients who were unconscious or could not speak. Other circumstances reported by the students as difficult were interactions with patients who were in pain, or

who were very emotional, and patients who were verbally abusive and lashing out. Most students indicated that what the patient was experiencing at the time determined what kind of interaction they would have with the patient. Chris commented that,

> "…sometimes it's a communication barrier or sometimes…you know they are very – they're in pain or they're not exactly themselves when they're in hospital no one's happy to be there, uh, but if – if for some reason you just don't get along … but if you don't …connect with your patient in some way, then I feel it hinders your relationship in that they might not always TELL you everything. They might not feel comfortable around you. They might not give you that extra information that would really help you out in your nursing priorities or your nursing care for them, so I think in that way it hinders."

Brenda felt that she did not know what to do in a situation where the patient was very emotional. She explained that,

> "During the summer I had a patient who had… it was an abortion of a sort. It wasn't…planned like it happened – miscarriage I guess but they had to abort the fetus and she was so upset about it and she was my patient. I haven't dealt with a patient who was so visibly upset and crying and just didn't know what to do and she was voice – this patient was voicing these things to me like I don't know what to do I just feel so along I just…I'm not sure and so I made time to like you know I'm here whenever – I'm here, you're my patient I'm here to listen to you from whenever you want

> like you can talk and she did she had a good talk with me for about 20 minutes or so and… she thanked me and she even gave me a hug for it so… I think that made her feel a lot better, but and again I felt… not awkward but I just felt bad because I didn't know what to say in that circumstance it's not something I've dealt with on my own or with anyone else so… I didn't know HOW to make a connection with her just besides to let her talk and listen to her story…."

Renee struggle with how she felt after caring for a difficulty patient. She described her experience as follows,

> "specifically, the one that really stands out in my mind probably because it's most recent in the rotation was the one individual…it was a struggle and I went home every day going oh I didn't…frustrated, I guess. Just…like I'm – you learn to leave part of your emotions at home I think and that's a hard thing for me because I'm a very emotional person…yeah, I feel frustrated, I guess, is the best way to put it – not necessarily frustrated as in I can't – ah, it's hard to describe – it's I feel like I haven't completely done my job, that I haven't been there the way I like to be for my patients…like you like to make that connection but they're frustrated or yelling at you and it's just …kinda go…I'm TRYING, I really am."

Nova described the experience of one of her colleagues with a patient who could not speak.

> "I've noticed as a student…and actually our instructor noticed it…the nurses were caring for a patient and the patient was always – not so

> cooperative with care. He couldn't speak, he couldn't voice anything but he was also just lying there and just kind of hmm not lifeless but maybe listless [laughs] and one of the students had the opportunity to be in there with him one day and he was young – he was 21 – and just lying there and she noticed that he had an iPod at the side of his bed and on a whim, maybe a feeling, she put it on him and turned it on and he just absolutely lit up and the student shared that with us and she was sharing how good she felt and how great it was to be able to communicate with that patient…."

In some circumstances, the students indicated that the patients thought of the student in another role other than caregiver and the patient relied on the nurse for the formal or professional care. The students perceived this to be a hindrance to interacting in a positive way with the patient, and to building trust and developing relationships with the patient and the staff. Marie described an encounter whereby the patient was still relying on the primary nurse after the student assumed care. She described it this way,

> "…in clinical situation maybe I've had patients that I've had my primary nurse be their nurse for several shifts and I come on as a new student with this primary nurse watching over me and I've had patients that maybe…aren't willing to build that connection with me and again it could be because I'm…uncomfortable with the situation because I know that they're still relying on this nurse and that I'm coming in as a new nursing being supervised by this primary nurse. Yeah in my experience that's

> been…kind of a hindrance on… building a relationship because the patient knows the primary nurse is still looking after them and the primary nurse is there… if the need to talk and maybe just seeing me as someone… there to meet their needs…."

Students were aware of the importance of interacting in a meaningful way to build trust and to develop relationships with the patients. They suggested that many of the nurses went in and did the tasks and skills for the patients, and did not always take the time for more interactions to gain the trust and build relationships with patients. Sam described it this way,

> "…I don't want to stereotype but some…not older nurses like I'm talking…baby boomers but the people who graduated just you know 4 and 5 years before me, myself, I feel I…that they are very…and I don't want to say they are careless – they still do their job, they're sort of good at it but I notice that they DON'T connect and they DON'T make an effort to do so, and that they – they're very – they're very disconnected from their patients and their job."

Many students acknowledged that this is not how they were taught, however this is what they were seeing in practice. Casey commented on what she felt was a disconnect between the patients and the nurses, leading her to think that nurses where not connecting at a deeper level and that the patients' experience could be negatively affected. She described it as follows,

> "Uh, well…there is kind of that…disconnect I feel between patients and staff like the staff member's a higher-up or they're just...they're there to

> do their job and their patient is just there to be helped kind of thing, so if…if nurses just walk in to just do a task they have a professional relationship with them but they're not…connecting at a deeper level, which they probably should be because that would make a patient's experience so much more…pleasant and it could lead to better outcomes. They [patients] might not feel so lonely or abandoned or it could probably lead to better outcomes."

Perhaps the economic and physical restraints in the system creates a situation where nurses focus on tasks to the exclusion of focusing on their interactions with patients. In reflecting on staff nurses' practice, many students commented on the "tick" boxes where they enter patients' data, for example, vital signs, bowels movements, and lung sounds. Sam said that, "there's one little box where you can fill in the psychosocial and if that…." Many students expressed that this did not represent the complete picture of caring for one's patient.

Being a student. Most students commented on the need to have very good communication skills and a repository of communication strategies in order to positively interact with the patients. They also added the need to be self-aware regarding one's communication skills. Chris indicated that,

> "Um, I think you have to be self-aware of how YOU communicate and work on your OWN communication…it's huge as a nurse because your patients watch you a lot more than they listen to you, and you need that. It's, it's how you talk to people, it's how you look at people, how you work with your colleagues AND your patients. It's just…you have to be

> so self-aware…the more independence we have in things the more self-aware we have to be."

According to many students, their communication labs focused on teaching them how to communicate with patients who were cognitively intact. They commented frequently that they would like more support with strategies on how to interact with patients who present with challenges that make it difficult to interact with them. This was a significant response as students also commented on the frustration and incompetence they felt when they couldn't interact or had difficulty interacting with patients. Students stressed the need to want to know more. Chris suggested that,

> "I think the biggest thing with nursing students is that…we're still learning so we're very…pliable almost in the ways we talk with people. Like we're all different people but in school we learn you know this is how you talk with people, this is how you not, you open – use open-ended questions so that you start discussion and you get to know more but I think we have the time as well, like we're able to sit down and foster these relationships and gain connections which helps us …."

Many students indicated that building trust was critical to establishing a positive relationship with the patients. They commented on their role as students and the perception of patients of them as students, adding that some patients were nervous with students caring for them. Most students added that by spending more time with them, the patients became more comfortable with students. Casey explained it as follows,

> "Uh…I think that when patients and families hear the word student they kind of… get a little nervous so that's a… an obstacle that you have to get over, but then I also think that once they see that you're able to spend more time with them than maybe a staff nurse, that makes them a little bit more comfortable because they don't think that you have the knowledge that the staff do, so in one way it's good and one way it's bad."

When connecting with their patients, most students suggested that their age and that of patients was not a concern. Brenda commented that, "I don't really have an issue with different ages." Many students indicated they connected better with older patients. Nova described it this way,

> "The older patients I find it easier to connect with. You show them respect and you give then the care that they need. That stems from a personal belief that the older population should be respected. They've lived through hard times and they're turning to us for help now because they can't help themselves anymore…the younger generation, I don't have any problems caring for them at all. I like listening to what they have to say."

Geneva added that,

> "just because they have more life experience and it makes it…um…I don't know – I just feel a, a, a more comfort level connecting with older individuals…older people have just been there they've done that. They have a – I guess they're more …focused, they're able to focus more."

As the average age for students in this study was 21 years, a significant number of the students indicated that patients commented on how young they

were. For the most part, students were able to provide a good response to the patient. Other students interpreted this to mean that they were too young to be doing their job, they felt that patients didn't trust them, and that perhaps they did not have the experience to care for them. Casey described her experience this way,

> "I'm very young looking. Most people ask me how old I am and for the most part I do have a very good response…but I also get the people who I'm younger than most of their grandchildren and they don't really want to talk to me or they don't think that I'm qualified or they are uncomfortable talking to me about stuff like sexual health or like that happened in postpartum."

Sam described it this way, "at first I don't think that they [patients] trusted me because they thought that I was quite young. I don't think they were sure about how experienced I was…." Geneva stated that, "Uh…I always feel awkward…looking after…patients that are in my same – that are my same age." When looking after their age contemporaries, students indicated they were aware of their professional boundaries. Marie explained that, "I …find personally I have a harder time connecting with younger patients. I don't know if that's because I'm more cautious of crossing the professional boundary with younger patients, but yeah, I find it easier to connect with older patients…." Students commented on the age factor of the student being a benefit and a hindrance to providing care. Most students shared that providing care for the older person was much easier. There could be a number of reasons for this. Many students revealed that they

were raised in multigenerational families and had to look after, in some cases, parents and grandparents. Other students mentioned that their mothers and grandmothers were nurses, and that they were a great influence on how to work with the older patients. Students generally spoke about the respect they had for the older patients and the life experiences they shared that influenced how the student would care for them.

Gender was not a concern when connecting with their patients. Casey indicated that, "I've never actually experienced a problem with gender differences with dealing with males or females." Whereas, Nova said that,

> "it really depends about [on] the patient. Women seem to be more comfortable with women I've noticed because I get a lot of comment back well you have the same parts as I do, you know, you've seen it all before…With men they get a little bit uncomfortable if you're doing personal hygiene care on them, just feeling I think again vulnerable that somebody's looking at their most intimate parts."

According to some students, being young and looking after patients of the opposite gender was sometimes problematic. However, they commented that with more experience in the program, they were able to pick up on patient cues and intervene appropriately. Nova described it this way,

> "…I've seen a couple of times where the patient is a little bit uncomfortable with me as a young nurse looking after them, specifically with young men I get a little bit – probably they feel vulnerable I think and a bit out of place if you…some strange nurse looking after you that's your

> age uh it kind of goes against maybe what you're feeling socially and what's acceptable and the trends. That's what I've noticed but overall I like working with everybody." Nova added that, "Now as a fourth-year student it doesn't really bother me at all. I've noticed that the patients to their level if I sense that they're feeling really uncomfortable I'll try to either let them have as much autonomy as I can in the situation or I'll get somebody else in if I can."

Student-faculty context. Students commented on the generational differences among the students, nursing staff and clinical nursing faculty. They indicated that it was easier to relate to the younger nurses and clinical nursing faculty. They also shared that they had much respect for the experience and knowledge of the older nurses and instructors. Nova described it this way,

> "I do notice the generational differences with nursing and nursing instructors. I find that I have to display a lot of respect if I'm able to display respect to the older nursing staff or the older nursing instructors and show them that I'm willing to learn and listen. I'm not there to give them attitude or disrespect, then I find the relationship is built a lot quicker…I know it works [laughs] so the younger generation, I can relate to a lot more. They have some of the same ideas as I do and some of the same nursing tactics and principles that I have so it's a lot easier to relate with them, but I do find I like working with the older staff as well because of their experience and the knowledge base. There's some things that they

> know that there's no way a textbook will teach you or a new nurse might know…if you can get that respect and be respectful."

As discussed earlier, interaction is described as "a mutual influence by two or more persons via the communication process" (Brilhart & Galanes, 1990, p. 5). Most clinical nursing faculty agreed that there is a difference between connection and a relationship, and between connection and an interaction, but you need strong communication skills for all aspects. Most clinical nursing faculty indicated that some of the students really struggled with the interpersonal communication with patients. They [faculty] agreed that developing the teacher-student interaction was an important first step. The clinical nursing faculty commented on exercises they do with students during orientation to role model the behaviours and encourage interaction. Chelsea indicated that,

> "one of the things that I do with my students during orientation is that I spend about 45 minutes on introductions. So we go around the table and we…I have everybody say something. The I go back and say OK: "This is Ruth. And she told me that she has a dog named Joe." "This is Willy and she told me that she grew up in Wetaskiwin." I do that. I give one statement. And then I say OK now it is your turn. And then I make each student go around and say one thing. And you can't repeat. So it gets fun, because by the time we get to the end, they are running out of things or they can't remember. And then you start to watch the group dynamics. You start to see, how are they going to problem solve…a it is a good way to connect. To me it is one of the most important things…this is a

> wonderful way to start building that team. And to start learning about each other."

Taylor added that,

> "I actually do something quite similar to that. A lot of it is because I want that student/teacher connection first"…"I think if I had that interaction that conveys confidence, comfort and relaxation – then, that is going to transfer into the clinical area. Typically what I find in a clinical area – which is what I taught predominately – is that they are very afraid to go into the clinical area. So I find that if they have a rapport with me, and I set them up for success …then I find that that actually clears the way for fear to be dispelled which is typically what they have in the very beginning…I think that role-modeling is extremely important."

By introducing these exercises with students, clinical nursing faculty hoped that the students would use similar strategies when interacting with patients. Gracie commented that, "…I try to do that [student/teacher connection] first, and then that makes me feel that I can facilitate that patient-student connection as well. And give them the confidence and tools that they need for that." Clinical nursing faculty agreed that having such an exercise with students at the beginning of the semester was beneficial. Chelsea suggested: "I think that if I had that interaction with them [students] that conveys confidence, comfort and relaxation – then, that is going to transfer into the clinical area."

A few students did not share this opinion. Sara reported that,

> "…part of being a good leader is being able to form connections and I think even if you have to form connections with your staff, to encourage them to have really good patient care, you need to be able to do that and I'm finding that…even our instructors WILL not form a connection with us, and that's how I THRIVE under being able to go to my instructor and say you know what – I have the dumbest question and please don't make a fool of me – just yes or no, treat me with some respect and I'll go on my way but…even our instructors won't ask you where you're from, or won't ask you what you like to do. They're not willing to make that connection because I think they're scared that they might be biased in their marking etc. but I like to see that my instructor cares about ME because I relate that to how they would care about the patient, because you, you, you look to them as a role model as well but they're – they need to care about you somehow and they need to be able to say you know what – I'm gonna care about you and the we're gonna be caring people towards the patients together, and I'm gonna care enough about you to be able to kind of push you and to make these connections because I can make a connection with you so…and I've had that with…two instructors…out of…the…eight."

Perhaps the clinical nursing faculty need to be more explicit in what they are attempting to role model for the students. Perhaps the students are expecting a more concrete explanation, and may be missing the obvious, to help them assimilate what the clinical nursing faculty are trying to role model.

Other clinical nursing faculty suggested that there are students with whom they cannot always get along or that their interactions are not positive in nature. Gracie indicated that "Because we cannot always get along with everybody. So you have to acknowledge that – I just can't make a connection with this student. And that is going to affect her practice. So my role is to see if I can make changes to facilitate his or her success."

Most students were supportive of the positive role modeling clinical nursing faculty portrayed. They found it helpful to emulate those behaviours in practice when interacting with patients. Casey stated that, "Well I find their [clinical nursing faculty] ease of conversation and ease of picking out what's important are very …admirable and something that I hope to be better at as I grow as a nurse…."

Other students shared a different experience when interacting with the clinical nursing faculty, and how the experience was a motivator to keep going in the program. Sam indicated that,

> "I started this [nursing program] because I wanted to ….I wanted to help people – in particular I wanted to help – I wanted to give hope to the hopeless and give a voice to the people who couldn't speak for themselves and I absolutely love what I do and I - what I got from the experience with the tutor I didn't connect with that was really didn't get along with me and threatened to fail me on numerous occasions, was that I went home and SO – and I discovered what was so devastating about this experience is that this woman was threatening to take this profession, this

> what I do – to take that away from me and I – when I sit down and I think about …what I would do if I wasn't a nurse, I just can't think of what that would be. There's just nothing else that I think I would be good at and there's just nothing else that I want to do. This is …this is it, and I will do what I'm doing at any cost, and if that means that I have to leave [the province] – which I, I don't fortunately plan to do anyway – then that I'm going to leave and I would have, I would have left [the province] rather than…than do anything else."

Knowing they were being graded had an impact on what kind of interaction many students had with their patients. In this circumstance, most students focused on the skills and tasks, hindering the opportunity to develop trust and build relationships and get to know the patient in a more meaningful way. Herman described it this way,

> "well getting graded, making sure our charting is good, making sure all the meds are given, making an error and getting called to court for something…that's uh…you don't get called into court if you didn't have a nice conversation with the family but I think that's more the essence of nursing and should be more the focus."

Students and clinical nursing faculty indicated that initial interactions with the patients were crucial to moving forward with building trust and developing relationships. The patient context, such as pain, and being a student were important elements when students interacted with patients. Students indicated that they wanted more support and strategies to help them interact with patients. Age

and gender were important considerations in the student-patient context. They were not identified as a major concern for most students. Within the context of student-faculty, clinical nursing faculty indicated the importance of role modelling teacher-student interaction and student-patient interaction to prepare students to work with patients. Students acknowledged they learned from these role modelling experiences. They also commented on being graded on their performance in their role as the student and how this set the precedent to focus on skills and tasks. Other students commented on the interactions with the clinical nursing faculty that were not as positive, and how this was a motivator to continue to strive harder to improve.

Developing the ability to achieve mutuality prepares nursing students to authentically and purposively engage in more meaningful interactions with the patients and practice holistic nursing care.

Reciprocity

The second major component of the process of developing mutuality is reciprocity. Reciprocity is defined as “the practice of exchanging things with others for mutual benefit” (Oxford University Press, 2005). Marck (1990) wrote that therapeutic reciprocity “pertains to a phenomenon that is a mutual exchange of meaningful thoughts, feelings, and behaviour; is probabilistic, collaborative, instructive and empowering; and is subjectively and objectively referenced by personal and empirical data in a dyadic manner” (p. 52). In this circumstance, reciprocity involves a sharing of knowledge and information between the student and the patient. Moreover, this component may be described as that feature of the

process of developing mutuality in which the student is encouraged by the clinical nursing faculty to consider various perspectives, and to pursue alternative ways to approach patient situations for the purpose of interacting with the patient at a deeper level. Readiness for reciprocity and encouraging reciprocity were categories found in the second component in the process of developing mutuality. The students talked about ways to 'read' patients to determine if they were ready for reciprocity. They commented on using clinical tutors as role models for reciprocity. The students also described "ways of learning about teaching" that the clinical nursing faculty can do to encourage reciprocity. For example, the students wanted the clinical nursing faculty to role model behaviours about teaching with them to help them encourage reciprocity with their patients. The clinical nursing faculty described two ways in which they engage in this process with the students: incidentally through role modelling behaviour and purposively by assessing the students' knowledge, skill and judgements.

Readiness for reciprocity. Students indicated that picking up on cues, using communication strategies including small talk and humor, seeking common ground, and limiting personal disclosure were beneficial to developing reciprocity. Students talked about ways to 'read' patients to determine if they were ready for reciprocity. Brenda suggested that, "…if they're constantly not making eye contact or they're really short answers or…they turn away just body language they're – they don't want to talk then I don't pursue it too hard but – uh…I guess yeah a lot through body language and verbal cues and whatnot if they even want – want to have that connection at that moment so…."

Geneva added this experience,

> "Uh…well, one time… uh… walked into this patient's room and I tried like you know doing the same thing that I usually do like maybe talk about the weather or what he was watching or just saying hi you know, and how was your lunch, and I got really short, abrupt answers from him, and…uh…just little comments like okay well I need to take your blood pressure and then he was like okay fine do whichever you – but the other half – whatever you have to do, right, and the, and then he'd be looking away from me not looking AT me or like down or anything like that so I SENSED that there was some sort of like he isn't really happy today I guess, uh, and that felt…that felt a little bit awkward because like okay well…uh…how am I going to I guess talk to my patient more a little bit, uh, because if you can guide a little bit of some sort of…uh, I guess connection or rapport, right, it makes it that much easier to provide uh…teaching."

Students revealed situations, such as a crying patient, that made it harder to engage in reciprocity. The students also expressed their feelings when confronted with these experiences. Brenda described it this way,

> "I wouldn't be comfortable with so even the crying patient I wasn't too comfortable with. I did to to…I don't know if it was my charge nurse it was one of the other nurse I was working with as I said like you know she's crying a lot, I don't feel I can do a lot for her like what should I do and I don't remember what they said but instances where I don't know or I

> don't have experience I find I have to find someone because I …I feel pretty useless if I don't know what I am doing."

Christine internalized the situation with a difficult patient as being something she needed to 'get over'. She expressed her concerns as follows,

> "I knew that it was my problem that I just needed to get over this…confidence issue. I feel like confidence was the reason for it. With the lady in this last clinical that I spoke about, she – yeah I needed to talk to my tutor and my peers and just be like WHA, what did I just DEAL with like how could I have done this better? I feel SO incompetent with my care, and it's difficult sharing those situations of you know frustration and incompetence because…I find that in nursing it's not usually just one situation that makes you feel frustrated and incompetent; it's MANY; it's one after the other after the other and then it just builds up but then try and relay that to someone, it – the significance is not…you can't share the significance because it's personal, it's very internal, the way that you're perceiving these things, and the other person can't perceive it the way that you…did, so it's good to talk about but I didn't …I didn't feel settled after speaking with my tutor or my peers about the situation. I think it's something that I needed to deal with by myself and the way I dealt with it, it was a year later when I dealt with this patient in THIS clinical where I was able to go in with interventions, practice them…like put myself there in the moment with this patient and not…think of any prior…experiences that could bias or cloud my judgment."

Even though they did not achieve reciprocity when they encountered difficulties with some patients, the students continued to provide care. They did comment that they did not have added information, such as if the patient's employment status, family situation, distance from home, and what does this experience mean to him/her. Geneva felt that her patient experience was a like roadblock. She stated,

> "that was a roadblock. I felt like – okay well…you know…I could just provide…like I can provide…all the necessary care that I need to do right, but then I didn't have any other extra information that I usually have… to anticipate…things for discharge, you know, like that…it's hard to find those things out if you don't…have some sort of connection to be able to ask those questions that needed to be asked."

Other students indicated that when the patients did not communicate with them, then they were not sharing information, and in such encounters there is no reciprocal exchange of knowledge and information. Channy believed that,

> "…if you have a poor connection with them, that relationship doesn't have necessarily a bright future because they don't want to work with you, they don't want to communicate with you. You ask them about their pain, they don't want to TELL you about it. They just want their medication and it just – to me it just gets…I've SEEN it get worse and worse."

Some students had difficulty articulating their role which made it difficult for them to engage in reciprocity. Wallace stated, "I take their [patient] situation, I understand it and I see what problems need to be fixed with them." Another

student indicated “connection assumes that you’re are uh connected to their life in some way; a relationship is where their feelings affect you – there’s more of a sympathetic relationship as opposed to an empathic connection.” Some students had difficulty articulating the boundaries in a professional relationship. This could potentially encourage reciprocity of an unprofessional nature. For example, Jasmin indicated that her conversation with her patient was a normal conversation “that like you have with your friends or your family”… “I liked her [patient] more than my other patients.”

Encouraging Reciprocity. In their quest for professional identity, students progress from imitating the clinical nursing faculty behaviour to integrating that behavior to suit new circumstances. Students require support and reinforcement during this adaptation process. Students talked at length about how they would encourage reciprocity with their patients, and how the approach, focus and attitude of the clinical nursing faculty and the nurses could foster a good learning environment or not for them.

Students indicated a number of different ways that they would engage with the patients to encourage reciprocity. Most encounters began with eye contact and facial expressions. Other non-verbal communication strategies included body language, such as hand gestures and body position of the student and patient, and the student and the patient’s tone of voice. Nova shared,

> “You have to be able to be connected to your patient, whether the connection is therapeutic or not that depends on HOW you’re connected…to the patient but the moment you walk into the room the

> patient's already looking at you to see who you are and how you are, I guess, if you will – body language says a lot. If you walk into a room and you're all tensed up and maybe have a scowl on your face, they're not gonna feel very safe around you and they're not gonna feel open like they can talk to you, but if you walk in the with a smile on your face like this and you have the ease in your step, the they feel open to you and already that connection has begun."

Chris added that,

> "Uh, verbal and nonverbal [communication] it's really important. I've learned especially this year sometimes the patients are watching you a lot more than they're listening to you so they want to see how you react to things they say and they want to see your body language so it's really important as a nurse I've learned to be very aware, no sighing or eye-rolling or anything because that can take across as rudeness. A student should always appear confident even if you're not always maybe confident."

Casey indicated that,

> "I try not to stand over the patient more, maybe uh…get a more comfortable stance, sit down or kneel down so I'm at their level. Also touch if it's appropriate like the touch on the shoulder or the hand if that's appropriate…body language from them and myself I feel more comfortable when I've made a connection rather than me just going into

> the room, seeing what they want and then…leaving. I'm more comfortable having a conversation with them."

Students revealed they learned very quickly those behaviours of nurses who they would emulate to encourage reciprocity because of how effective they were with the patients, and the behaviours of nurses they would not adopt because they recognized the behaviours were not effective in engaging the patients in conversation. Channy suggested that,

> "…you see, you just SEE things, you SEE nurses who connect well with patients and you see nurses who don't and you see where each goes right and each goes wrong I guess per se – just some of them aren't very talkative, some of them aren't very open…and that's…that's just how it is and you can feel those things and you can – I feel like you can just…see them so I have my role models are just the ones I see…who…I don't want to say do it right because there's not necessarily a right or wrong way but…Yeah those who can connect well and you know I can go to them and say you know so-and-so is maybe difficult this way. What do you know, what can I talk about with them to find some common ground or whatever, and I find many nurses are…you know, ready and willing to share and …to inform you."

Student-faculty reciprocity. Students disclosed mixed responses when asked who they would go to for help if they had difficulty in getting more knowledge and information from the patient. They indicated they would go to the nurses on the unit. Jasmin stated, "They're always right there…you can walk out

of the room, there's an RN there…who knows the unit." Moreover, this student indicated "I don't like going to our instructors because they're always busy doing other things",… "page your instructor takes 10, 15 minutes to see them. Why would you do that…."

Students commented that some clinical nursing faculty did not role model the reciprocal exchange for the students to help them understand and develop that additional knowledge that would help them build a deeper relationship with the patients. Perry (2009) suggests that through role-modelling nurses are able "to teach practical nursing procedures, and also are able to teach the often unspoken facets of exemplary nursing care" (p. 40). Jasmin indicated that the student-tutor interaction is often about skills. She suggested that,

> "…most of the time when you're with the faculty and the staff members it's just like…when you're doing a skill they come and watch and help you, but like…they don't show anything about developing relationships with patients. Half the time they don't even TALK to the patients so…they don't really spend any time with the patients or talk with the patients…they may say hi, I'm the instructor, how are you"… "like they do all this crap about like our models like…but…you don't ever see them using it and they be like oh use the McGill model – okay great, like…thanks for your help."

Suzy echoed Jasmin's comments saying that, "they [clinical nursing faculty] mostly help you on your skills, not your …connection…I think that's expected of

us in fourth year …no one really goes over like how to communicate with a person properly because we all think [in CBL class]…that we're okay with it."

Students indicated that they would like the clinical nursing faculty to demonstrate for them what it is they are expecting from students in a reciprocal exchange with their patients. Students were wanting to know the "what" and "how" to enact reciprocity. Emma suggested that the student-tutor relationship should be reflective of the student-patient relationship or resemble it. She described it this way,

> "like I often feel like tutors – like we are in a way their patients like we're the ones that they're educating, teaching, developing awareness like supporting, encouraging right, and that we're doing the work of working with the actual patients so I think that kind of reflects that same…[be able to develop that further relationship] …and I think there also needs to be a bit of discernment on behalf of the tutors because I think some students are not interested in …a conversation like that…they want to do their work and go home."

Some students expressed that the tutors were treating them in a 'cookie-cutter' fashion and not as individuals. As each experience differs, then how do the students learn the strategies of gleaning knowledge and information when they are exposed to perhaps only one approach. Emma indicated that, "so there's no like 'cookie-cutter' way of teaching students because…ultimately we're all different and I think we're in small enough groups of students that teachers should be able to …alter the way that they teach or relate to students, given that they only have 7

or 8 students – I don't think that that's unfeasible for them to …be able to do that."

The clinical nursing faculty revealed that they encourage reciprocity in a variety of ways. Two prominent ways to nurture reciprocity were identified as incidentally and purposively. The term 'incidental' is defined as "happening by chance in connection with something else" (The Oxford Canadian Dictionary of Current English, 2005, p. 411). Clinical nursing faculty role model, facilitate, and guide the students as they initiate and continue in conversation with their patients, and thus indirectly inspire the students' practice of exchanging ideas for mutual benefit. They described a number of ways in which they assist students to connect with patients. Many clinical nursing faculty said they use role modeling as a method to teach students. McGurk (2008) reports that a role model "is a person who exemplifies behaviour or a social role for others to emulate. In health care the, term is associated with the development of clinical competence and expertise" (p. 51). Role modelling has been linked with transformational leadership, "where change is believed to be brought about by charismatic and well-organized leaders who exemplify new ways of thinking" (Price & Price, 2009, p. 51). It is "a means of discovering 'the knowledge embedded in clinical practice" (Charters, 2000, p. 29). Moreover, Davies (1993) concludes, "clinical role modeling, then, is perceived in positive and negative ways by students, can lead to the development of particular skills and techniques during clinical placement, and is seen as a major influence in professional socialization" (p. 629). In the case of students connecting with their patients, the clinical nursing faculty

serves as a powerful role model for the student, and the students found this to be most effective during orientation and during post-conferences.

Bartz (2007), believes role models "serve as a catalyst to transform as they instruct, counsel, guide, and facilitate the development of others" (p. 7). As role models, the clinical nursing faculty can do much to enhance or detract from the students' clinical experience. Indeed, it was discovered that when the clinical nursing faculty role models, facilitates and guides, it is not necessarily done with the express purpose of encouraging reciprocity between students and patients. However, clinical nursing faculty indicated that it was important for the students to get to know them and vice versa thus creating the atmosphere for reciprocity to happen. Gracie gave this example,

"I am the first one to tell my stuff and they have to tell something about me as we go around the circle. So it is not just the students; it is me too. And I give them lots of information. I tell them about my kids, about my grand-kids, my dogs, my cats, and chickens. And then the next one will come along. And she will say, "Oh, I was born in Wetaskiwin."

The development of reciprocity from this perspective then is being kindled by chance. By this I mean, the clinical nursing faculty do not set out deliberately to encourage the students to develop reciprocity, but rather it develops unintentionally as a result of their [clinical nursing faculty] behaviours.

Unlike something that happens by chance or incidentally, purposive is defined as "having or tending to fulfill a conscious purpose or design" (Merriam-Webster On-Line Dictionary, 2012). It is intentional or deliberate. The clinical

nursing faculty acts as a conduit in motivating the students to interact with patients at a deeper level to stimulate an atmosphere for mutual exchange and sharing of information. In this instance, the clinical nursing faculty deliberately questions the students' knowledge base, decision-making and actions, and assesses their ability or not to engage in a meaningful reciprocal exchange with the patient. Questions are used to direct the thinking process, provoke interest, stimulate and challenge the student, influence the social and emotional milieu of the teaching/learning environment, promote discussion, and evaluate learning. Clinical nursing faculty agreed that most students in fourth year did not need as much assistance to interact with patients for the purpose of reciprocity. In fact, Chelsea suggested that a mental health posting helped. She indicated that,

> "they seem to have gone through the mental health component. And it seems to have really assisted them in their communication skills…usually by fourth year they have those [skills] and they at least know about those tools. And they can draw them out if they need to." She continued "occasionally, there is a student that you might have to say: "Well OK, now your tutor needs to know the answers to these questions. You need to know where you patient lives. You need to know if they have brothers and sisters. So, figure out - are you going to use a geno-map? Are you going to use an echo-map? Are you going to ask them about church? These are the questions you need to have answers in. So play the student card."

Assessing for high self-awareness and esteem deemed to be positive attributes, indicated whether students were more likely to engage in communication that

encouraged reciprocity. Jojo offered this comment regarding these positive attributes,

> "I think that students who are comfortable with themselves and comfortable with their practice – are able to reach out to make an easier connection with the patient. If the student is unsure of what they are doing; if they are in a situation where they are not comfortable doing the task, they tend to close up a little bit. And the communication, the engagement – suffers. I believe it comes from the comfort level of the student themselves. And then that can be generated with increased engagement with the client."

Indeed, findings indicated that clinical nursing faculty engaged in both incidental and purposive learning moments with students. However, the students did not always pick up on what the clinical nursing faculty were trying to portray. Jojo provided this example,

> "…a patient that had his wife at the beside on most days. And one morning we came in and his wife wasn't there. And my student was at the next bed doing vital signs. And I just walked into the room and I asked "Where is your wife?" And he started to tear-up. So I sat down and held his hand and listened to his story. And then afterwards, …I said to the student "Did you catch that conversation?" Because he avoided me going out of the room. He looked past me. Um, he avoided eye contact with me. And I said, "Did you catch part of the conversation?" And he said: "Yeah, better you than me." And I thought OK. He is very focused on the

> physical, and he wasn't able to go to that next level to get that true contact or connection with the patients. And I carried that conversation, mostly, to set an example for him. But that didn't work positively in this case."

Perhaps the student was disengaged and not interested in what was happening around him. Is this a behaviour common to students to tune out when the environment becomes too chaotic? Is this a symptom of students, that is, focusing on skills and tasks with their patients, when they are trying to manage the work and get through the day? Perhaps it is a learned behavior from some nurses as role models who aim to do the tasks and skills only.

Tutors as role models. Most students indicated a number of people who served as their role models, many of whom established this role prior to entering nursing school. They included family members such as mothers, fathers, siblings, relatives who were nurses, and trainers in 4H classes. The clinical nursing faculty reiterated their part as a role model was to facilitate, support, and guide the students in their quest to share knowledge and information with their patients. They indicated that a huge part of this role is trust. Reciprocal trust then provides a foundation that "continues to foster trust and competence over time" (Thorne & Robinson, 1988, p. 787). Clinical nursing faculty and students, in the process of their developing relationship, represents a complex and dynamic exchange of clarifying expectations and negotiating trust (De Raeve, 2002b; Doucet, 2009; Newman, 2007; Sellman, 2007; Thorne & Robinson, 1988; Watson, 2001). Clinical nursing faculty implied that the students' past experiences with other tutors was an important part of the conversation to have with them. They

commented on the fact that if the students had poor role models in the past, then it becomes very difficult for students to change their ways and trust and accept the guidance and support of other clinical nursing faculty. Jojo suggested,

> "if there has been a tutor in their past – who has been very authoritative and very demanding, and very focused on the physical skills – it becomes very difficult for the student to switch gears. By the same token, if they come to [this course] in that kind of atmosphere, they are the ones that are most grateful and very much acknowledging at the end of the [course] – how much they were able to re-connect with why they wanted to be in nursing. But I think it is tough for some of those students to switch emphasis."

What students had accomplished in the previous three years was an important area for clinical nursing faculty to explore. Given that this was a 4th year medical-surgical rotation, perhaps some students had never had a surgical rotation thus necessitating foundational knowledge about care of the surgical patient and then going the next level to interact with the patient. Chelsea explains this statement further,

> "In some respects the student can only be what the clinical instructor, or the clinical tutor, is. If they are task focused, the student is going to be task focused…they [students] are always trying to please us, as individuals. "What do you want?" Rather than to just let their own self flow through in their nursing care. I think we need to let students be who

they are. Be a student. Our role is to facilitate their growth, not to dictate their growth."

Missed opportunities. Clinical practice provides powerful learning experiences for the students (Benner, Sutphen, Leonard, & Day, 2010). As students continue in the program, the clinical nursing faculty facilitate the student's engagement with the patient in their unique context, and to appreciate what the holistic nature of this experience means for the patient (Benner et al, 2010). Benner et al. found that nursing educators use pedagogies of contextualization. Contextualization means "taking into account the response of the particular patient in the situation, including the patient's history, interrelationships between physiological systems, social interactions with others, and responses to the particular environment" (Benner et al, 2010, p. 46). At an advanced level, the clinical nursing faculty might ask students to liken new clinical situations with situations the students' encountered before.

Often these "contexts" are not attended to and not talked about, thus being overshadowed by the physical presentation of the patient and any legal issues that may arise. One clinical nursing faculty shared that when she worked with the students, she attended to the tasks only. Alexis stated, "I did not take into account the students' interactions with their patients." In doing so, perhaps the clinical nursing faculty missed valuable "teaching moments" with the students. Perhaps the students missed out on significant learning opportunities, for example, exchanging ideas with the clinical nursing faculty about the importance of a holistic approach to care, what this means for the patients and the students, what

should the student be assessing, and how to intervene appropriately. Moreover, there may have been a disconnect between the clinical nursing faculty and students, subsequently creating missed opportunities to genuinely engage with the students and be able to provide constructive feedback regarding the therapeutic nature of the students reciprocal exchange with their patients.

Although clinical nursing faculty concurred that some students needed support to interact effectively with patients, and most students at this level of the program required less assistance, the findings of this study indicated otherwise. Most students were eager to learn more about how to interact, how to develop meaningful relationships with difficult patients, and how to integrate 'holistic nursing' into their practice. The students indicated that the length of response time and a focus on task and skills by the clinical nursing faculty were impediments for students being able to develop reciprocity and facilitate a meaningful conversation about holistic care with the clinical nursing faculty.

The clinical nursing faculty agreed that the experiences students had with clinical nursing faculty earlier in the program may impede their ability to engage in reciprocity and encourage the students to do what the clinical nursing faculty know, the students should be doing at this level in the program. Indeed, this disconnect could provide the opportunity for lack of clarity regarding the responsibility and accountability of students and clinical nursing faculty roles. This could further affect the student's ability to engage in meaningful dialogue (reciprocity) with the patient, and hinder the exchange and sharing of information that is fundamental to this part of the process of developing mutuality.

Emotional Investment

Hawthorne and Yurovich (2002) wrote "the meaning of nursing is embodied by the patient and the nurse and unfolds when they meet in the clinical encounter, a place where life's dramas are played out" (p. 54). According to Welch and Wellard (2005), "presence can be referred to as an interhuman connection between a nurse and the patient who exist in harmony with each other, who sense the experiences and feelings of each other, and who both grow through such experiences and feelings" (p. 7). The third major component of the process of developing mutuality then is referred to as emotional investment; a condition whereby the physical needs and the human caring side of nursing are embodied (Gallagher-Lepak & Kubsch, 2009). Hawthorne and Yurovich (2002) wrote "The patient looks to the nurse for solace, refuge, and comfort, while the nurse has the ability to understand the patient's loneliness, fear, and pain. Faith in the meaning of this deeply human experience brings joy, nourishment and enrichment to both patient and nurse" (p. 54). Other categories inherent in emotional investment included trust, respect, being genuinely present, being in the moment, bearing witness, being empathetic, and being mentally and emotionally prepared. Students who have developed a recognition and acknowledgement of their own feelings, and who can be sensitive to the feelings of others, have the ability to show empathy, compassion and understanding (Watson, 1979). Twerski (2008), suggests that "Sensitivity to the circumstances and feelings of others is the cornerstone of human relationships. The seasons of sunshine and joy and alternatively the seasons of cold and suffering spare no mortal the desperate need

for caring and understanding from his fellow human beings." Watson (1999) describes a 'transpersonal caring relationship' as being "a special kind of human care relationship – a union with another person – high regard for the whole person and their being-in-the-world" (p. 63). Gallagher-Lepak and Kubsch (2009), state "transpersonal caring interventions build a deep connection with the patient providing comfort, pain control, well-being, wholeness, and healing" (p. 171).

Getting to know patients. Christiansen and Jensen (2008) suggested that "the student's ability to cultivate emotional qualities in caring is usually associated with her e**x**periences in relationship to patients" (p. 326). Most students commented on the need to assess themselves and assess the situation, thus determining their readiness [mental preparedness] for this emotional investment with the patient. They agreed that this [readiness] can really affect how the patient perceives you. Christine described it this way,

> "I think in all successful…patient-nurse relationships you have to be able to go into a situation with a patient and…before you go into it, assess yourself and assess the situation so…questions you need to ask yourself about the patient is like who are – who is the patient, what are their condition like right now, what do you think they're going to WANT, so try and anticipate their needs, and yourself how are you feeling right now, are you being…are you under great time constraints, are you stressed out, are you…are you happy with…the day so far, because all of those can really affect how…the patient perceives you when you walk into the room,

so when you've got all these things sorted out and realize that… you're mentally prepared."

The students take a risk when investing emotionally. That is, they go beyond just giving a conditioned response. For example, the students move out of their comfort zone, are not on autopilot, and go beyond the routine of everyday occurrences. Hochschild (1983) describes 'deep acting' whereby the person [student] "actually feels that which is communicated" (p. 33). That is, "we must dwell on what it is that we want to feel and what we must do to induce the feeling" (p.47). In this way, the nursing student might conceive of him or herself in the place of the patient thereby coming to 'know' the patients responses in a therapeutic context. Emotional investment then reflects the students and the patients' feelings on a much deeper level. Some students indicated that they were able to achieve this step in their relationships with their patients, and why getting to this point was so important. Herman stated "it's getting to the emotional and mental, spiritual needs of your patient rather than just the physical part we tend to focus on in the hospital." Bill indicated "…you know, like no matter how…hard you care for someone, physically, if you don't care for them mentally then it could be completely useless to even care for them physically…." According to Gallagher-Lepak and Kubsch (2009), "caring is grounded in humanistic-altruistic values of concern, kindness, and empathy" (p. 174). Watson (1979) suggests that embodiment of this value system is "an attitude that becomes a will, an intention, a commitment, and conscious judgment that manifests itself in concrete acts of caring" (p. 43).

Many students indicated that they wanted to know their patients and really understand how they were feeling and how they could be there for them. Perry (2009) states, by "enriching someone else's life, they greatly enriched their own lives as well (p. 42). Susan described it as follows,

> "That's the reason I'm in nursing. I want to get to know my patients and I want to …I want really…understand how they're feeling and how I can be there for them, and it's a great feeling" "I think a therapeutic relationship…has a lot to do with not being afraid to, to look at somebody and see them for, for who they are – not necessarily just what they're saying, to look at their face and the emotions that they're expressing and…and…not judge, not…not even…well just to listen, just to listen and to understand and accept, I think, to I think no matter what you'll always come into situations that you, that you perhaps…feel…don't or can't relate to maybe, can't understand but I think that a therapeutic relationship just involves understanding and not being afraid to look at your, look at your patients and feel what they're feeling and…and…accept them for who they are."

The emotional component was revealed to be an important aspect of the relationship with the patients. In a helping-trusting relationship, the student brings openness, a holistic regard, empathy, and warmth to the relationship (Watson, 1979). Alexander described it this way,

> "…in a relationship I think there's got to be more than that [mutual interest]. There's got to be some sort of …some sort of emotional

> connection as well so connection again, but there's got to be this emotional component to what maybe what you're talking about maybe coming into the room, maybe sharing that space with a person."

Lucy indicated that, "I felt very privileged to actually kind of fill that spot [patient's daughter] but yet use that information to further her care." Geneva shared that she felt happy and confident and reassured that the patient would let her know when they needed something. She described it this way,

> "Uh…I feel happy and confident that I know that I'm doing my best work for my patient, and that gives me more confidence in my care that I … that I uh…give and it also gives me a kind of a reassurance that I know that…I – that my patient WILL tell me you know I have pain and not wait until they're absolutely in pain before they ring the call bell…or that they're not afraid to you know ask me any questions because that's what I'm there for too."

Christine recognized the uniqueness of each patient situation, and how exploring patients' beyond the physical component was important to glean helpful information to provide care for the patient at a deeper level. She described it this way,

> "I think it's important to not go into a patient or into a nurse-patient relationship expecting or thinking that you know everything about the patient or about the condition, so what I did with this patient was ask a lot of questions. She's got an ostomy. I have cared for a person with – or people with ostomies before – but just to…get a feeling of how SHE'S

> dealing with it and…and what her experience has been like so far with this flare-up, so to not go in and think that you're the be-all and know-all of everything but really genuinely hear what the patient has to say about her experience…I don't think the emotional necessarily happens day one. With this patient I had her for a few days and…on day…you know, two and three she was telling me – she started opening up about her boyfriend – NOT because I was asking specific questions but because she felt comfortable enough to TALK to me about it and to share her…share her like kind of. So she told me…you know about work, about life, about how she was feeling with everything, how her bosses are dealing with everything, time off of work – other social life. She even went into some of her…sexual life yesterday and how she deals with the ostomy so that's a REALLY personal thing and for her to feel comfortable enough to share that with me was…I think a success, knowing that we have created a relationship versus just a connection, something that…more than just a physical task. It goes into really wanting to …connect with someone and share with someone…on a much deeper level."

Christine suggested that it was really important to include the patient in the planning of their care. By doing so, it reduced the patient's ambiguity and uncertainty about the plan of care, thus promoting the emotional investment of student and patient. Christine explained it this way,

> "body language is really important. Oh, I'm a big supporter of Jean Watson's transpersonal caring and so I really strive to be genuinely

> present in all of my interactions and there are times when you're really, really busy but if you – I feel like if you can…put yourself in the position where you're square to the patient and shoulder is square you've got eye contact, not looking off in other directions trying to …remember what you have to do next but you're really present in that moment, and then you give THEM direction. This is what I'm going to do, I'll be back at this time, and then you can go off and do your other things, so I think that's also really important…because it lets them know that you've really listened and that you're coming back and what the plan of action is so they're not left with this ambiguity and uncertainty about the care that you're providing."

Many students talked about filling the emotional and psychological needs of the patient and in turn receiving something back, thus demonstrating the component of emotional investment. Christine described it this way,

> "A relationship is a connection…on the basic level as well as the non-basic level, where you're starting to …fill the emotional needs, the psychological needs…and in turn maybe you're getting something back as well. You're feeling…some sort of emotion from this connection as well and you feel…happy talking to the patient…content caring for the patient, versus if you don't have that…relationship…maybe as the nurse you're not getting as much back. It may be still pleasant caring for the patient but there's not that emotional connection."

Christine added that, “So as the nurse I would see – I see that [small talk] as a priority of care. This patient needs to talk. This is one of her needs at the moment, so we deal with that. I’m genuinely present in the conversation. I’m using these techniques to let her know that I can empathize with her completely. Yeah and in that way again we’re building the trusting relationship where she knows I’m gonna be there to listen to her and take care of her needs as they come.” Christine commented that, “if I’m able to fit in all my tasks AND get to the emotional…and psychological aspects of care as well, it’s been a good day.”

By reaching that deeper level with the patient, students found this experience quite rewarding. Christine described this as follows,

> “It is, quite rewarding. I could feel in the first weeks of the clinical when I wasn’t connecting to patients sort of like a tiredness. I felt obtuse like I was slow at trying to understand things but now my confidence kick-started me into…uh…knowing that I was able to care for patients on a higher level. It was – and then getting the validation from the patients with their physical…signs and also their verbal signs. It was – it’s SO rewarding and…I feel…like more energetic on the unit and more willing to just…take care of ANYONE’S needs whether it’s anything. I feel better able to balance my time which was really important – less stress…and just overall just happy to be where I am, so do I think that this study is important – yes I do because being able to connect with your patients can help you feel so much better as a student and I think as a practicing RN too, just job satisfaction in general.”

Channy expressed that,

> "How do you KNOW…you're connected. It's a feeling I can't really explain I guess. Uh…I don't know. Just good, happy, I don't really know how to explain it. You can just tell. You can just feel it. You just – you know. You both are very comfortable and it's a feeling in the room, in the area, just…that you just feel…connected."

This student commented on the patient's response saying,

> "I guess that's very individual, individual basis, um, depending on the patient but I guess with the particular one if I need to think about that one we'll just say…seems, happy, seemed content, seemed…trusting, willing to share, uh, even though he's not in his – he or she is not in their best condition, they're still you know they can still squeeze out a smile and…and like they did use their manners and show appreciation, appreciation for what you're doing even though they're not at their best."

Specialness of being a student. Students talked about the special role they have being a student. They commented on getting to really know the patients and their families, providing small errands for them that made a significant difference to their well-being, seeing their patients faces light up when they walked into the rooms, and being able to share a joke and laugh with their patients when circumstances [students and patients] where tough. Most students indicated that they were concerned that things may change when they graduate. Nova expressed that she hoped they don't. She described it this way,

> "…I think the specialness of being a student and being able to think of those little things like hey maybe that guy would like to listen to his iPod, those are things that I think maybe get forgotten once we leave the student body behind and take on the professional role of a staff nurse. So if anything in this study I hope that a lot of the students having similar experiences that they can share because I've heard a lot of other experiences similar to that where a student had that extra – not sense but extra – ability to perceive maybe what people need and usually something small, but to that person that receives it, it makes the biggest difference."

The goal of holistic nursing care is "to promote the betterment and well-being of the client by mutually participating with the client in changing health dynamics and direction of change as defined by the client …" (Canadian Holistic Nursing Association, 2012). The goal of holistic nursing, as described by the American Holistic Nurses Association, is to "treat and heal the whole person by recognizing the interconnectedness of body, mind, spirit, and environment" (American Holistic Nurses Association, 2012). Students struggled with trying to engage in holistic care. They noted that they learned the concept in theory but that it was not really encouraged in practice. Susan described it this way,

> "It's [holistic care] definitely something that we learn in theory"…"I don't think that holistic care is…is encouraged all that much or hasn't been in my personal experience and…what reinforces that to me is that we're…we're told to get our clinical instructors to come watch us do the skills that we've never…never had or that we're doing for the first time or

> they haven't seen us do yet, so they're coming in for our first catheter, our first IV start, hanging our IV medications, etc. etc. etc."

Perhaps because of the competing demands in the health care environment, holistic care is not a priority with nurses and clinical nursing faculty. This further reinforces the notion that skills and tasks are the focus for patient care. Many students indicated that the clinical nursing faculty predominantly see what you do such as skills. When the students are comfortable and confident with the skill, then they can continue to build a relationship with the patient. Susan suggested that,

> "it's just so skill-oriented…I wouldn't say that it's [holistic care] something that's…really promoted in the faculty. Mind you, it is, it is a huge – like it is a huge part of our theory and we know that it's important and I think that lots of us DO provide holistic care but it's not really the basis for…for our program."

In some circumstances, the students indicated that they were encouraged to pick their own patients, thus promoting the students role in meeting their own needs and interests, and further developing their holistic nature of practice. Emma indicated that,

> "…right now our tutor actually lets us pick our patients so we go through…Kardex and charts to kind of see what's interesting to us and what appeals to our…learning needs and time and I think like that's helpful in terms of…we're doing cases – we're taking care of people that have cases, for lack of a better word, that are interesting to us so I think

> there's…in that that allows like there's a bit of an appeal to learn about that person and what they've gone through and I think that facilitates…that a little bit."

Students indicated that they would like their clinical tutors to role model with them [students] what they [tutors] expect the students to do with their patients, that is, to share with them what they are actually trying to do with their [students'] patients. They want the tutors to portray the behaviours with students that will help them connect and to develop emotional investment, that is, embodying behaviours that facilitate the students learning beyond being able to do the tasks, and having a mutual exchange with the patients. Emma described it as follows,

> "…Like I often feel like tutors – like we are in a way their patients like we're the ones that they're educating, teaching, developing awareness like supporting, encouraging right and then we're doing the work of working with the actual patients…I think there needs to be a certain amount of…assessment from tutors in terms of what students actually want out of their clinical…I think teachers need to…kind of respect that and be able to challenge and push those students that really want to…some students get frustrated with a lack of challenge when they're looking for challenge; some students get frustrated with the really challenging tutor when they're not looking for that in their particular course…."

Many students commented that tutors could be more inquisitive with regard to the learning needs of the students, and facilitate assignments that were more

meaningful and closer aligned with students interests and development opportunities. They indicated that would be a motivation for them to learn. The students felt they could glean more from their clinical nursing faculty in terms of beyond this clinical placement experience. In relation to their nursing career, students were interested in tutors suggesting what might be a good "fit" for the student in terms of a first new graduate experience. Emma suggested that,

> "…I think tutors can play a role in…inquiring into what is interesting to students…I think if you're motivated to learn about something and someone's case then you're gonna be more…engaged in that active learning…I think…part of the appeal to go into nursing…you can nurse everywhere, and there's a type of nursing for everybody…I would like to see tutors more like facilitating those conversations…I've wanted to know THEIR [tutors] insight into the type of nursing that they see me…being able to do a bit of an assessment of their students and being able to then reflect a little bit of insight into areas that they might see…I think sometimes that like higher insights from people that have been in the profession for a number of years would be helpful…."

Many students indicated that clinical nursing faculty encouraged them to practice holistic care. Whereas, the interpretation of holistic care from the student perspective and the clinical nursing faculty perspective needs further exploration. The findings from the student perspective indicate that skills and tasks are the predominant focus for nurses and clinical nursing faculty.

Student-faculty context. Most clinical nursing faculty look for behaviours from students and patients that demonstrate that they are engaged with one another. Jojo indicated that she liked to see "if they [students] are truly connecting with the patient. And not just going in there and busying themselves with tasks. Are they truly focused on the patient? Are they saying hello? Not just the eye contact. But are they really connecting, spirit to spirit with the patient." Chelsea commented,

> "I think that students who are comfortable with themselves and comfortable with their practice – are able to reach out to make an easier connection with the patient. If the student is unsure of what they are doing; if they are in a situation where they are not comfortable with doing a task, they tend to close up a little bit. And the communication, the engagement – suffers."

Taylor indicated that "that feeling of sincerity is one of the qualities she looked for in the student." Grace explained it this way, "But do they like what they are doing? Do they like the person? Or at least care about the response of the patient? Are they considering more than the physical task that you mentioned? Are they considering the whole person?"

Clinical nursing faculty agreed that some students cannot reach that level of emotional investment with the patient. Chelsea said that, "I don't think that nursing students can go to that level. I don't think that nurses do in general – depends on the patient too." Clinical nursing faculty agreed that students can only be what the clinical instructor is. For example, if they are task focused, the student

is going to be task focused. Most clinical nursing faculty expected the students to go beyond the physical presentation and the skills and tasks necessary for patient care at this level in the program. They did however indicate circumstances where the students could not present information that was representing holistic care. Jojo indicated "when the student cannot tell me that aspect of care [psychosocial] …just the physical assessment incorporating the disease processes. That to me is not a holistic approach to care." Supporting this comment, Chelsea indicated that, "…then, you are not knowing the person." Perhaps some clinical nursing faculty were not clear in their communication with students to help them further develop their emotional qualities and the requisites for engaging in holistic care. Gracie suggested that, "I expect that a student would be able to see past the task and walk and chew gum at the same time – in other words make the connection. … use a sense of humour to see beyond the actual intervention."

Christine [student] summarized the essence of this component of mutuality [emotional investment] by suggesting,

> "I think the most important thing – I'll just say it again – nursing isn't about just the task; it's about holistic caring, caring for the patient as a human being…all aspects…um…and that's important not only for the patient as a human being…all aspects…um…and that's important not only for the patient to be able to feel…like they matter, but also for the nurse because it's REALLY rewarding and…you feel so much better about your job and yourself as a person and that…if those conditions are met you're less likely to feel the effects I think of burnout and …your job satisfaction

I think can be greatly increased when you're able to have a connection and a relationship with the patient."

Sometimes a struggle. Students could identify when they were not genuinely present or in the moment with their patients, and what that meant for them. Christine indicated that, "I felt…not genuinely present. I felt like I may have been rushing her care, trying my best to…meet the shallow needs in the moment so that I could get out." This student expressed, "I feel like if you don't connect, and you're just running in, doing tasks and getting out, you're not caring for the patient in the best way that you can, and you know we're taught from day one practice holistically." Perhaps the students are struggling with juggling many competing priorities and do not have the resources [human, physical and technical] to utilize to adequately organize, prioritize, and engage in holistic care. This may be a symptom of the changing environment of a health care system in crisis, one that potentially favours balancing budgets ahead of the need for a system that can adequately supply human, technical and physical resources in order to provide holistic care to patients. What is the clinical nursing faculty and nurses' role here in helping the students navigate in this environment, and provide care beyond the skills and tasks? Are the clinical nursing faculty recruited from this environment? Perhaps this way of practice becomes the status quo for nurses and some clinical nursing faulty. This then places a further gap between what is taught as evidence-based practice in the curriculum and what is witnessed and experienced in practice, and potentially instills uncertainty and ambiguity within the students. This situation reinforces the earlier notion of the interpretation or

misinterpretation regarding what is a therapeutic nurse-patient relationship and what is a professional relationship.

An important finding in the emotional investment component was that students referred to the relationship with their patients as a therapeutic relationship [therapeutic nurse-patient relationship]. This finding reflects Welch and Wellard's (2005) comment, "it is through presence, or intersubjectivity, that nurses can connect with patients and gain understanding of and mutual meaning from nurse-patient interactions" (p. 7). These students were able to enact the theory of a therapeutic nurse-patient relationship to practice and embody the tenets of holistic care with their patients (Watson, 2007). As indicated earlier, most students described this type of relationship [therapeutic] as doing the tasks only. Perhaps with the emphasis on skills and tasks by the clinical nursing faculty and the nurses, the student begins to associate this routine as being therapeutic in nature. The students may or may not be exposed to what a therapeutic relationship looks like in the practice setting, or perhaps they do not recognize it as being therapeutic in nature. Many students described the professional relationship as one that had much more meaning attached to it. Perhaps the students are acclimatized to practice within a professional relationship as interpreted by them through their nursing role models in the practice setting. These discoveries may explain why many students are engaging in the reciprocity component with their patients, while others are able to achieve emotional investment.

Conclusion

Berry (1985), wrote “we should not expect that the structure of the task or purpose ...under consideration should necessarily and in principle be a barrier to mutuality” (p. 65). Mutuality is not developed through one clinical experience, but rather it is a process that develops over time and with the experience of many opportunities for interaction and relationship development. For many students, three types of relationships where identified: the nurse-patient relationship, the social relationship and the professional relationship. Initially relationships tended to be task oriented and purpose defined. Most students identified this as the nurse-patient relationship. Students agreed that the social relationship was not one they would have with their patients. However, they did confirm that having developed social relationships prior to entering nursing school helped them interact and develop relationships with their patients. Most students indicated that the professional relationship was one in which they included the pathological, psychological and spiritual needs [holistic care] of the patient. There were few variations of these interpretations of relationships, meaning not all students were in agreement with these interpretations. The clinical nursing faculty also identified three similar types of relationships. They also did not agree on the characteristics inherent in each of the relationships. Remarkably, the students and the clinical nursing faculty did not always agree on the interpretations for the same relationship. Many key categories contributed to the students developing a successful relationship with their patients or not. The categories included verbal and non-verbal communication strategies, length of time for interactions, age of

patient, student, clinical nursing faculty, and staff, and gender of patient and student.

Readiness for reciprocity and encouraging reciprocity were categories found in the second component in the process of developing mutuality. Students indicated that picking up on cues, using communication strategies including small talk and humor, seeking common ground, and limiting personal disclosure were beneficial to developing reciprocity. Students talked about ways to 'read' patients to determine if they were ready for reciprocity. The students commented on using clinical tutors as role models to help them develop reciprocity. The students also described ways of learning and teaching that the clinical nursing faculty can do to encourage reciprocity. The clinical nursing faculty described two ways in which they engage in this process with the students: incidentally through role modelling behaviour and purposively by assessing the students' knowledge, skill and judgements.

Categories inherent in emotional investment included trust, respect, being genuinely present, being in the moment, bearing witness, being empathetic, and being mentally and emotionally prepared. Some students indicated that they were able to achieve this step in their relationships with their patients. Some clinical nursing faculty agreed that they wanted the students to reach this level of emotional investment. One clinical nursing faculty remarked that she did not think the students could reach this level. She did not think nurses did in general. Perhaps in her clinical practice with students the focus was on the tasks and skills and not the relational aspects of holistic care.

Developing mutuality articulates a nurse-patient relationship that embodies the philosophy of holistic nursing care (Curley, 1997). It develops best in an atmosphere of dialogue, interchange and problem solving. The clinical nursing faculty who seeks to encourage the students in the development of mutuality recognizes that the student's role is to question and seek explanations, and that the clinical nursing faculty's role is to provide support, encouragement and explanations. In due course, students who develop mutuality in the practice environment possess characteristics such as spontaneity, graciousness, being present in the moment, and being non-judgmental (Mitchell & Bournes, 2010; Parse, 2010; Watson, 1979). Moreover, they not only possess a holistic understanding of their patient's situation, but also are encouraged to question their nursing care and interventions to seek better outcomes for patients and their families.

CHAPTER V

SUMMARY, LIMITATIONS, IMPLICATIONS AND RECOMMENDATIONS

This study examined the process used by 4th year nursing students to develop and promote connecting with their patients. My reason for embarking on this study was motivated by a threefold concern: a) some students are readily able to develop meaningful connections with their patients and other students struggle to make connections; b) there are a variety of influences on how students are socialized into nursing, for example, the current health care environment, the quality of role modeling they observe, and the individual personal characteristics of both practicing nurses and patients'; and c) can nursing students engage in holistic nursing practice and challenge the status quo. Nonetheless, as the data emerged it became evident that there was a process occurring with 4th year students and patients to help them connect. The process is complex and identified as developing mutuality.

The process of developing mutuality in nursing student-patient connections was determined to be an interactive process in which students and patients engaged in authentic, meaningful dialogue to come to a much deeper understanding and connection with each other. This process was discovered to comprise three major components: a) interaction, b) reciprocity, and c) emotional investment. Interaction may be described as that coming together of two strangers to establish a relationship in which to converse. The students described three

types of relationships: the therapeutic nurse-client relationship, a social relationship and a professional relationship.

The second major component of the process of developing mutuality is reciprocity. This component may be described as that component of the process of developing mutuality in which interaction takes place and is influenced by many factors, for example, the student, the patient, the staff and the clinical nursing faculty.

In discussing the practice experience, the students stressed the significance of the role that the patients play in developing a process of mutuality with them. The students eagerly provided descriptions of those aspects that they believed to be essential to a successful relationship that for some students eventually added to the development of mutuality with their patients in the practice setting. Similarly, clinical nursing faculty provided their perceptions regarding what they considered to constitute a successful student-patient connection. In doing so, the clinical nursing faculty also revealed the characteristics which they believe to be critical to that experience. Within this context, incidental learning, such as role modelling for students, and purposive learning, such as working with and supporting students, emerged from the data as key behaviours evidenced by the clinical nursing faculty in their interactions with students and patients pertinent to the process of developing mutuality.

As the data emerged in this study, several interesting discoveries of particular significance surfaced and are again worth highlighting. For example, a major feature in the development and promotion of the process of developing

mutuality was found to be what constitutes a therapeutic relationship. Many students indicated that the therapeutic nurse-patient relationship was skill and task focused. These students indicated that the professional relationship was one that had more meaning and depth. Curiously, the few students who achieved the level of emotional investment with their patients commented on the relationship being therapeutic in nature. For some students then, the tenets of the therapeutic nurse-patient relationship learned in year one were embodied throughout the four years. These students were able to demonstrate the behaviours of emotional investment and practice holistic care with their patients.

A second discovery pertains to the process of developing mutuality, which was skewed more toward the purposive learning than the incidental realm of this process. Students indicated that there was a major focus on skills and tasks that was reinforced by the clinical nursing faculty and the nurses. The students indicated they wanted more support in how to interact and be with patients, especially the difficult ones. This discovery is especially relevant to the future planning and implementation of clinical experiences for basic baccalaureate nursing students. It is also particularly significant for the role that clinical nursing faculty take on in that experience to ensure the development and promotion of the process of mutuality.

Limitations

All research studies have some limitations, the most apparent being those of time, expertise, funds and creativity (Myrick, 1998, p. 112). Acknowledging these constraints, this study was also prone to the possibility of difficulties

imposed by personal bias, analytical creativity and interview technique (Freshwater, 2005; Jasper, 2005; Mantzoukas, 2005).

The length of time during which this study was conducted may be perceived to be a limitation. Data were collected for a total of 12 weeks. During this time the nursing student participants taking part in this study were assigned to a medical or surgical unit in the second last clinical practicum of the program. It is likely that the depth and richness of the data may have been disproportionately influenced by this limited time frame. My analytical creativity may have been a limitation impacting the depth and richness of the emergent conceptual framework (Freshwater, 2005; Glaser, 1978; Jasper, 2005; Mantzoukas, 2005).

During the research process, personal bias is always a potential concern from the identification of the problem to the completion of the study. In grounded theory, delaying hypothesis generation until data collection is well established (Glaser, 1978) protects against bias, an approach to data collection referred to as "theoretical sensitivity" or the ability to "see relevant data" (Glaser, 1978; Kelle, 2006). Theoretical sensitivity is nurtured by entering "the setting with as few predetermined ideas as possible…especially logically deducted prior hypotheses" (Glaser, 1978, p. 3). My personal bias was not abandoned by simply adopting a neutral inductive approach. I was cautious throughout the entire research process in order to avoid unsupported thinking that could bias the emerging theory (Freshwater, 2005; Jasper, 2005).

Relying on the interviews and focus group as the primary data sources may have potentially introduced significant constraints and biases. Interviewees

may have provided me with information that they 'wished' me to hear. For example, Wallace stated a number of times "Does that answer your question?" and "Is that answering your question…?" perhaps indicating that he was seeking approval for his answers and hoping that what he was saying fit with what I was expecting in the responses. Given this likelihood, I took considerable care to ensure that the interviews and focus group were conducted in an impartial manner. For example, I did not disclose any personal bias, anticipate any responses, or any other manner of influence during the interviews or the focus group. An assistant moderator was engaged as time keeper, to take comprehensive notes, operate the tape recorder, and handle environmental conditions such as refreshments, lighting and seating of participants (Krueger, 1998a). She also noted body language throughout the discussion. The assistant moderator was a valuable second set of eyes and ears thus increasing the total accumulation of data and the validity of the analysis.

Finally, the pandemonium in the health care environment at the time of this study precluded the opportunity to study patients. Eliciting the perceptions of nursing students and clinical nursing faculty, and not the perceptions of patients, about nursing students connecting with patients, could be perceived as a potential limitation.

Implications

Based on the findings of this study, four key implications were revealed. Students commented on their communication labs in year one as being helpful to begin interactions with a patients. However, they indicated that a lab in how to

interact with difficult patients, such as the patient with a diagnosis of dementia or Alzheimer would be helpful. Students indicated that clinical nursing faculty helped them with their skills, for example, giving medications on time. However, they acknowledged that during their CBL classes, tutors do not address this communication concern. Further, Suzy states "no one really goes over…how to communicate with a person properly because we all think…that we're okay with it." Students learn to communicate and interact with cognitively intact patients early in their undergraduate education. As patient encounters become more complex, students struggle with how to communicate and develop meaningful relationships with patients. This finding would suggest a significant review by clinical nursing faculty. Given that communication strategies are integral to initiating interactions, the first part in developing mutuality, then is it sufficient to leave it to chance in the practice setting or is it more appropriate that it be facilitated directly in the classroom setting? What resources are available for clinical nursing faculty and students to facilitate students to interact positively with difficult patients? What supports are available for the clinical nursing faculty to facilitate this learning?

Students and clinical nursing faculty defined three types of relationships. However, there was a disconnect in the interpretations of each type of relationship among students, among clinical nursing faculty and students, and among clinical nursing faculty. If it is assumed that students learn the therapeutic nurse-client relationship in year one, how then do they come to know in 4th year that professional relationships and social relationships are part of how they interact

with patients as well. Furthermore, findings in this study revealed that most students did not consistently define the elements of each of these relationships in the same way. This finding was also true of the clinical nursing faculty. Perhaps then what constitutes holistic care is being interpreted in different ways, thus complicating the role the student is expecting to enact, and perhaps a contradictory expectation the clinical nursing faculty are anticipating from the student. This finding suggests a substantial examination of this issue by the clinical nursing faculty. Given that the nurse-client relationship is foundational to establishing the basis for holistic care for the patient, is it sufficient to leave these many interpretations of the relationship to possibilities or is it more apropos that it be facilitated directly in the classroom, CBL classes, and in the practice setting.

Many students and clinical nursing faculty did not specifically articulate the concepts of self-assessment and reflection. Students indicated the clinical nursing faculty helped them with their skills. However, they acknowledged that during their CBL classes and in post-conferences when they talked about their experiences, they did not find the experience helpful. Perhaps these concepts are not developed well enough from the student's and tutor's perspectives to engage in a meaning dialogue. If it is assumed that the concept of self-assessment is an essential component of the student learning, the clinical nursing faculty and the nurses to identify gaps in knowledge, act on them and improve nursing practice, then perhaps there should be a more focused, facilitated approach in the curriculum. Students value reflection as a means of learning, however they are only developing these skills. Journal writing and debriefing are important to

develop reflective skills. What resources are available for clinical nursing faculty and students to facilitate students to develop their self-assessment and reflection skills? What supports are available for the clinical nursing faculty to facilitate this learning?

Clinical nursing faculty's actions such as role modeling, facilitating, guiding and prioritizing function indirectly to prompt the development of mutuality in baccalaureate nursing students in the practice setting. To a smaller extent, nursing students' development of mutuality is ignited directly when their patients, clinical nursing faculty, and nursing staff probe them for deeper meaning and clarification of their actions. From this finding then, it can be supposed that the process of mutuality is being developed in the practice setting, though primarily by chance or serendipitously as a result of student, patient, staff and clinical nursing faculty actions. This finding suggests a significant inquiry for clinical nursing faculty. If one assumes that baccalaureate nursing education is promoting the development of mutuality, then is it sufficient to leave it to chance in the practice setting or is it more appropriately be facilitated directly? With regard to the latter, there are strategies that can be initiated to provide ongoing support for clinical nursing faculty in their attempts to facilitate the development of mutuality within nursing students while under their guidance. How can clinical nursing faculty provide this support?

Recommendations

Based on the findings from this study, the following recommendations are proposed. Considerable thought ought to be given to the patients assigned to

students for achieving student and/or course objectives (developing mutuality). This would also include careful consideration and/or enquiry concerning patient receptivity to students being assigned to them. Additionally, clinical nursing faculty should continuously monitor the students' experience through regular meetings with students, patients and staff in the practice setting. The nature of this planning not only would provide knowledge of the practice experience, but would also provide the clinical nursing faculty with a direct impression of students connections with their patients.

Self-assessment and reflection need to be prominent concepts threaded throughout each classroom and practice teaching milieu. A suggestion is that clinical nursing faculty attend professional development opportunities to engage in activities that will foster their work with helping students' complete meaningful self-assessments that cover all domains relevant to clinical practice. Clinical nursing faculty are encouraged to engage in professional development opportunities that identify teacher competencies that could be used in nursing education to develop students' reflection skills. Clinical nursing faculty need to have time and opportunities to practice and reflect on their experiences in a context that is conducive to these activities. Aronson, Neihaus, Hill-Sakurai, Lai and O'Sullivan (2012) found "that the provision of critical reflective guidelines improved performance and that feedback on both content reflective ability also improved performance" (p. 807).

Clinical nursing faculty ought to assume a more active role in fostering the development of mutuality in students. The concept of developing mutuality is a

timely one. Because the findings in this study reflect the notion that students are more likely to engage in developing mutuality incidentally rather than purposively, it would be prudent on the part of clinical nursing faculty to spend some quality time with students themselves. This would allow clinical nursing faculty the opportunity to provide students with information about the significance of developing mutuality with their patients, the possible opportunities that present in each component in developing mutuality, and the ways in which the information can be used more efficiently and effectively so that students may develop deeper, more meaningful, mutually reciprocal experiences with their patients, and ultimately provide holistic care. The opportunity for clinical nursing faculty to spend time in a one-on-one relationship with the student would provide a role modelling experience (Donaldson & Carter, 2005; Hayajneh, 2011; Price & Price, 2009). Working with students in this manner would also foster a closer working relationship between nursing education and nursing practice to reduce current perceived theory-practice gaps, thus fostering the practice of therapeutic nurse-patient relationships and holistic nursing care. In fact there is a best practice guideline for "establishing therapeutic relationships" (RNAO, 2002, 2006), and Eaton, Henderson and Winch (2007) comment on enhancing nurses' capacity to facilitate learning in nursing students through effective dissemination and uptake of best practice guidelines. Such an opportunity could only serve to benefit nursing students, patients, clinical nursing faculty and the profession in general. Benner et al (2010) calls for radical transformation of nursing education. The recommendations set forth in their work could be the template for change at the

micro, meso, and macro levels of nursing education (e.g. “develop pedagogies that keep students focused on the patient’s experience” p. 220).

Further research ought to be carried out to examine the dynamic of developing mutuality in nursing education. Given the expectation that clinical nursing faculty foster the development of mutuality, then I will put forward the following questions: a) how do clinical nursing faculty articulate their understanding of the development of mutuality; b) what strategies can clinical nursing faculty identify that assist them in promoting the development of mutuality in their teaching; c) how can clinical nursing faculty demonstrate effective leadership and mentoring in promoting the development of mutuality in the practice setting; d) what means are in place to consider the extent to which clinical nursing faculty promote the development of mutuality with their students; and e) are there specific approaches and attitudes that facilitate clinical nursing faculty in teaching students to develop mutuality (Myrick, 1998).

Research is recommended to examine the process of developing mutuality, not only in baccalaureate nursing education but also within the setting of graduate nursing education and other practice-based disciplines. Further research involving students and patients is essential to understand the processes inherent in this relationship. Clinical nursing faculty and students’ reflective practice is another critical area for further study.

Theory generation is essential for the development and advancement of a theoretical base for clinical teaching in nursing education. This study provides a systematic, well-substantiated theory that reflects the richness of the process of

developing mutuality in the practice experience. It has generated a credible theory that can be used to understand the contextual reality of how students connect with their patients and how this connection facilitates or hinders the development of mutuality or not in 4th year nursing students in the practice setting.

The process of developing mutuality provides a framework with which to strengthen the student-patient connection as a teaching/learning experience. As a result of the findings of this study, it has become evident to me that the role of clinical nursing faculty can play an active role in nurturing the development of mutuality in clinical teaching and supervision. The scholarship of teaching/learning capabilities of the clinical nursing faculty is very important to the success of student learning, both in the classroom and the practice setting. By taking on a more active role in how the students connect with their patients, clinical nursing faculty can monitor the development and promotion of the development of mutuality of nursing students. Moreover, clinical nursing faculty can provide students with the benefit of their expertise to ensure the more frequent use of appropriate strategies that directly facilitate the development of mutuality in baccalaureate nursing students as they engage in the therapeutic nurse-patient relationships that leads to holistic nursing care.

Knowledge-Sharing Strategies

Knowledge transfer concerns all activities that generate, use, apply or exploit knowledge. This study would not be complete without the transfer of this knowledge beyond my academic pursuit. I believe my work is important to the future of the nursing profession. It can provide valuable insights into why

developing mutuality with students is necessary for them to be able to practice holistically, and potentially affect better patient outcomes.

I will use several knowledge-sharing strategies in multiple contexts for dissemination and knowledge transfer of the process, findings and discussion of this research study. I have created a 'knowledge-sharing' matrix that includes opportunities for writing, a permanent knowledge sharing product; for face-to-face networking such as conferences, lectures and meetings; and use of the web, for instance, webct and blackboard sites for asynchronous chats, and synchronous chats using application software such as Virtual Classroom and SKYPE. I plan to publish the findings from this work in a peer reviewed nursing education journal with a research focus to target nursing educators and researchers. I realize this venue can become outdated, and for this reason have chosen a variety of other venues for the purposes of knowledge transfer regarding the structure, process, and outcomes of this study. Speaking and on-line opportunities might include audio and video conferencing, much like what was utilized in our PhD program courses to facilitate distance learning and distributed learning. More information about the 'knowledge-sharing' matrix is included in Appendix V.

Conclusion

The process of developing mutuality comprised three major components: initial interaction, reciprocity and emotional investment. Significant findings during the process of developing mutuality are what constitutes a therapeutic relationship, and the skew toward purposive learning. Four key implications were identified, "How to communicate with difficult patients…", the nature of "the

nurse-client relationship…", the development of 'self-assessment' and 'reflection'…", and clinical nursing faculty "role modeling, facilitating, guiding, and prioritizing…" students' learning. The following recommendations are offered as a means to transform education for faculty and nursing students: professional develop opportunities for clinical nursing faculty, determining appropriate clinical experiences that reflect needs identified by students and clinical nursing faculty, and fostering the development of holistic nursing care with students. Areas for further research include: the process of student and patient connection from the patients perspective, and exploration of clinical nursing faculty and students actual reflective practice. A number of strategies were posed to disseminate this research in a variety of venues.

References

Altschul, A. (1971). Relationships between patients and nurses in psychiatric wards. *International Journal of Nursing Studies, 8*, 179-187.

American Holistic Nursing Association. (2012). http://www.ahna.org/.

Andrews, G. J., Brodie, D. A., Andrews, J. P., Hillan, E., Thomas, B. G., Wong, J., et al. (2006). Professional roles and communications in clinical placements: A qualitative study of nursing students' perceptions and some models for practice. *International Journal of Nursing Studies, 43*, 861-874.

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research, 6*(3), 379-393.

Arnold, E. C., & Boggs, K. U. (2007). *Interpersonal relationships: Professional communication skills for nurses* (5th ed.). St. Louis, MI: Saunders Elsevier.

Aronson, L., Niehaus, B., Hill-Sakurai, L., Lai, C., & O'Sullivan, P. S. (2012). A comparison of two methods of teaching reflective ability in Year 3 medical students. *Medical Education, 46*, 807-814.

Ashmore, R., & Banks, D. (2004). Student nurses' use of their interpersonal skills within clinical role-plays. *Nurse Education Today, 24*, 20-29.

Bail, K. S. (2007). Engaging nurses in patient care: Clinical reflection by a student nurse. *Contemporary Nurse, 25*, 156-162.

Bargad, A., & Hyde, J. S. (1991). Women's studies: A study of feminist identity development in women. *Psychology of Women Quarterly, 15*(2), 181-201.

Barker, P. & Buchanan-Baker, P. (2005). *The Tidal model: A guide for mental health professionals.* New York: Brunner-Routledge.

Bartz, R. (2007). A true role model. *Orthopedics, 30*(1), 7.

Baxter, P., Norman, G. (2011). Self-assessment of self deception? A lack of association between nursing students' self-assessment and performance. *Journal of Advanced Nursing, 67*(11), 2406-2413.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). Educating nurses: A call for radical transformation. San Francisco, CA: Jossey-Bass.

Benoliel, J. Q. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research, 6*(3), 406-428.

Berry, D. L. (1985). *Mutuality: The vision of Martin Buber*. Albany, NY: State University of New York Press.

Boud, D., Keogh, R., & Walker, D. (1985). *Reflection, turning experience into learning*. New York: Kogan Page.

Breeze, J. A., & Repper, J. (1998). Struggling for control: The care experiences of 'difficult' patients in mental health services. *Journal of Advanced Nursing, 28*, 1301-1311.

Brilhart, J. K., & Galanes, G. J. (1989). Effective group discussion (6^{th} ed.). Dubuque, IA: Wm. C. Brown Publishers.

Brixey, M. J., & Mahon, S. M. (2010). A self-assessment tool for oncology nurses: Preliminary implementation and evaluation. *Clinical Journal of Oncology Nursing, 14*(4), 474-480.

Bryant, L. (2009). Patients as partners. *Practice Nurse, 37*(4), 47-51.

Buber, M. (1957). Elements of the interhuman. *Psychiatry*, *20*(2), 105-113.

Buber, M. (1966). *The knowledge of man: A philosophy of the interhuman*. New York: Harper Torchbooks.

Bulman, C., Lathlean, J., & Gobbi, M. (2012). The concept of reflection in nursing: Qualitative findings on student and teacher perspectives. *Nursing Education Today, 32*, e8-e13.

Canadian Nurses Association. (2008). *Code of ethics for registered nurses*. Ottawa: Author.

Canadian Holistic Nursing Association. (2012). http://www.chna.ca/.

Caris-Verhallen, W. M. C., Kerkstra, A., Bensing, J. M., & Grypdonck, M. H. L. (2000). Effects of video interaction analysis training on nurse-patient communication in the care of the elderly. *Patient Education and Counselling, 39*(1), 91-103.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13-24.

Chan, D. S. (2004). Nursing students' perceptions of hospital learning environments – An Australian perspective. *International Journal of Nursing Education Scholarship, 1*(1), article 4. Retrieved August 24, 2008, from http://www.bepress.com/ijnes/vol4/iss1/art9.

Charters, A. (2000). Role modeling as a teaching method. *Emergency Nurse*, *7*(10), 25-29.

Chinn, P. (2001). Teaching and learning: From the editor. *Advances in Nursing Science, 23*(3), v-vi.

Christiansen, B., & Jensen, K. (2008). Emotional learning within the framework of nursing education. *Nurse Education in Practice, 8,* 326-332.

Cody, W. K. (2000). Nursing science frameworks for practice and research as means of knowing self. *Nursing Science Quarterly, 13*(3), 188-195.

Coffey, S. (2006). The nurse-patient relationship in cancer care as a shared covenant: A concept analysis. *Advances in Nursing Science, 29*(4), 308-323.

Cogin, J. (2012). Are generational differences in work values fact or fiction? Multi-country evidence and implications. *International Journal of Human Resource Management, 23*(11), 2268-2294.

College and Association of Registered Nurses of Alberta. (2009a). *No nursing shortage? Clarifying CARNA's information on how RNs spend their time at work*. Edmonton, AB: Author.

College and Association of Registered Nurses of Alberta. (2009b). *Registered nurses respond to Alberta Health Services budget*. Edmonton, AB: Author.

College of Nurses of Ontario. (2008). *National competencies in the context of entry-level registered nurse practice.* Toronto: Author.

College of Nurses of Ontario. (2002, revised 2009). *Professional standards.* Toronto: Author.

College of Nurses of Ontario. (2008). *National competencies in the context of entry-level registered nurse practice.* Toronto: Author.

College of Nurses of Ontario. (2002, revised 2006). *Therapeutic nurse-client relationship.* Toronto: Author.

Collins English Dictionary. (2012). *Collins English dictionary on-line*. Retrieved from: www.collinsdictionary.com.

Craik, K., & Sustrik, J. (2009). *UNA responds to AHS dismissal of code of conduct complaint.* Edmonton, AB: United Nurses of Alberta.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Curley, M. A. Q. (1997). Mutuality: An expression of nursing presence. *Journal of Pediatric Nursing, 12*(4), 208-213.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing, 31*(6), 1476-1484.

Davies, E. (1993). Clinical role modeling: Uncovering hidden knowledge. *Journal of Advanced Nursing, 18*(4), 627-636.

Davies, P. (1994). Non-verbal communication with patients. *British Journal of Nursing, 3*, 220-223.

Dekker_Groen, A. M., van der Schaaf, M. F., Stokking, K. M. (2011). Teacher competencies required for developing reflection skills of nursing students. *Journal of Advanced Nursing, 67*(7), 1568-1579.

Delmar, C. 92006). The phenomenology of life phenomena: In a nursing context. *Nursing Philosophy, 7*, 235-246.

De Raeve, L. (2002a). The modification of emotional responses: A problem for trust in nurse-patient relationships. *Nursing Ethics, 9*(5), 465-471.

De Raeve, L. (2002b). Trust and trustworthiness in nurse-patient relationships. *Nursing Philosophy, 3,* 152-162.

Diekelmann, N. (2001). Narrative pedagogy: Heideggerian hermeneutical analyses of the lived experiences of students, teachers and clinicians. *Advances in Nursing Science, 23*(3), 53-71.

Diekelmann, N., & Mikol, C. (2003). Knowing and connecting: Competing demands and creating student-friendly and teacher-friendly nursing curricula. *Journal of Nursing Education, 42*(9), 385-389.

Donaldson, J. H., & Carter, D. (2005). The value of role modeling: Perceptions of undergraduate and diploma nursing (adult) students. *Nurse Education in Practice, 5,* 353-359.

Doucet, T. J. (2009). Trusting another: A Parse research method study. *Nursing Science Quarterly, 22*(3), 259-266.

Drew, N. (1986). Exclusion and confirmation: A phenomenology of patients' lived experience with caregivers. *Image: Journal of Nursing Scholarship, 18,* 39-43.

Eaton, E., Henderson, A., & Winch, S. (2007). Enhancing nurses' capacity to facilitate learning in nursing students: Effective dissemination and uptake of best practice guidelines. *International Journal of Nursing Practice, 13,* 316-320.

Evans, A. M. (2007). Transference in the nurse-patient relationship. *Journal of Psychiatric and Mental Health Nursing, 14,* 189-195.

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counselling psychology research. *Journal of Counselling Psychology, 52*(2), 156-166.

Fleischer, S., Berg, A., Zimmerman, M., Wuste, K., & Behrens, J. (2009). Nurse-patient interaction and communication: A systematic literature review. *Journal of Public Health, 17,* 339-353.

Fosbinder, D. (1994). Patient perceptions of nursing care: An emerging theory of interpersonal competence. *Journal of Advanced Nursing, 20,* 1085-1093.

Ferrari, E. (2006). Academic education's contribution to the nurse-patient relationship. *Nursing Standard, 21*(10), 35-40.

Forchuk, C. (1995). Uniqueness within the nurse client relationship. *Archives of Psychiatric Nursing, 9*(1), 34-39.

Forchuk, C., Westwell, J., Martin, M., Bamber-Azzapardi, W., Kosterewa-Tolman, D., & Hux, M. (2000). The developing nurse-client relationship: Nurses' perspectives. *Nurse Scientist, 6*(1), 3-10.

Freshwater, D. (2005). Writing, rigour and reflexivity in nursing research. *Journal of Research in Nursing, 10*(3), 311-315.

Gallagher-Lepak, D., & Kubsch, S. (2009). Transpersonal caring: A nursing practice guideline. *Holistic Nursing Practice, 23*(3), 171-182.

Georges, J. M., & McGuire, S. S. (2004). Deconstructing clinical pathways: Mapping the landscape of health care. *Advances in Nursing Science, 27*(1), 2-11.

Gillespie, M. (2002). Student-teacher connection in clinical nursing education. *Journal of Advanced Nursing, 37*, 566-576.

Gillespie, M. (2005). Student-teacher connections: A place of possibility. *Journal of Advanced Nursing, 52*(4), 211-219.

Gilligan, C. (1993). *In a different voice: A psychological theory and women's development* (3rd ed.). Cambridge, MA: Harvard University.

Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: The Sociology Press.

Glaser, B. (1998*). Doing grounded theory: Issues and discussions*. Mill Valley, CA: The Sociology Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine Publishing Company.

Glaser, B., & Strauss, A. (1995, renewed). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine Publishing Company.

Gastmans, C. (1998). Interpersonal relations in nursing: A philosophical-ethical analysis of the work of Hildegard E. Peplau. *Journal of Advanced Nursing*, *28*(6), 1312-1319.

Gordon, C., Ellis-Hill, C., Ashburn, A. (2009). The use of conversational analysis: Nurse-patient interaction in communication disability after stroke. *Journal of Advanced Nursing, 65*(3), 544-553.

Gortner, S. R. (1993). Nursing's syntax revisited. A critique of philosophies said to influence nursing theories. *Image: Journal of Nursing Scholarship, 22*, 101-105.

Harriston, T., Pistolessi, T., & Stephen, T. (1989). Assessing nurses' communication: A cross-sectional study. *Western Journal of Nursing Research, 11*, 75-91.

Hartigan-Rogers, J. A., Cobbett, S. L., Amirault, M. A., & Muise-Davis, M. E. (2007). Nursing graduates' perceptions of their undergraduate clinical placement. *International Journal of Nursing Education Scholarship, 4*(1), article 9. Retrieved August 24, 2008, from: http://www.bepress.com/ijnes/vol4/iss1/art9.

Hawthorne, D. L., & Yurkovich, N. J. (2002). Nursing and science: A critical question. *Canadian Journal of Nursing Research, 34*(2), 53-64.

Hayajneh, F. (2011). Role model clinical instructor as perceived by Jordanian nursing students. *Journal of Research in Nursing, 16*(1), 23-32.

Heath, H. (2006). Exploring the influences and use of the literature during a grounded theory study. *Journal of Research in Nursing, 11*(6), 519-528.

Heifner, C. (1993). Positive connectedness in the psychiatric nurse-patient relationship. *Archives of Psychiatric Nursing, 7*(1), 11-15.

Hewston, A. (1995). Nurses' power in interactions with patients. *Journal of Advanced Nursing, 21*, 75-82.

Hickson, H. (2011). Critical reflection: Reflecting on learning to be reflective. *Reflective Practice: International and Multidisciplinary Perspectives, 12*(6), 829-839.

Hochschild, A. R. (1983). *The managed heart: Commercialization of human feeling*. Berkley: University of California Press.

Hood, L. E., Olson, J. K., & Allen, M. (2007). Learning to care for spiritual needs: Connecting spiritually. *Qualitative Health Research, 17*(9), 1198-1206.

Hweidi, I. M., & Al-Obeisat, S. M. (2006). Jordanian nursing students' attitudes toward the elderly. *Nurse Education Today, 26,* 23-30.

Idczak, S. E. (2007). I am a nurse: Nursing students learn the art and science of nursing. *Nursing Education Perspectives*, *28*(2), 66-71.

Inions, N. J. (2009). *Response to letter of complaint*. Edmonton, AB: Alberta Health Services.

Ironside, P., Diekelmann, N., & Hirschmann, M. (2005a). Learning the practices of knowing and connecting: The voices of students. *Journal of Nursing Education*, *44*(4), 153-155.

Ironside, P., Diekelmann, N., & Hirschmann, M. (2005b). Students' voices: Listening to their experiences in practice education. *Journal of Nursing Education*, *44*(2), 49-52.

Irurita, V. F. (1999). Factors affecting the quality of nursing care: The patient's perspective. *International Journal of Nursing Practice, 5*, 86-94.

Jasper, M. A. (2005). Using reflective writing within research. *Journal of Research in Nursing, 10*(3), 247-260.

Jesse, D. E. (2010). Watson's philosophy and theory of transpersonal caring. In M. R. Alligood, & A. M. Tomey (7th ed.), *Nursing theorists and their work* (pp. 91-112). Maryland Heights, MO: Mosby Elsevier.

Jeon, Y-H. (2004). The application of grounded theory and symbolic interactionism. *Scandinavian Journal of Caring Sciences, 18*, 249-256.

Johnson, D. E. (1980). The behavioral systems model for nursing. In J. P. Riehl & C. Roy (Eds.). *Conceptual models for nursing practice* (pp. 207-216). New York: Appleton-Century-Crofts.

Johnson, J. L. (1994). A dialectical examination of nursing art. *Advances in Nursing Science*, *17*(1), 1-14.

Johnson, M., & Webb, C. (1995). The power struggle of social judgment: Struggle and negotiation in the nursing process. *Nurse Education Today, 15*, 83-89.

Karaoz, S. (2005). Turkish nursing students' perception of caring. *Nurse Education Today, 25*, 31-40.

Kelle, U. (2006). "Emergence" vs. "forcing" of empirical data? A crucial problem of "Grounded Theory" reconsidered. *Forum: Qualitative Social Research, 6*(2). Retrieved from: http://www.qualitative-research.net/fqs/.

Kim, H. S. (2000). An integrative framework for conceptualizing clients: A proposal for a nursing perspective in the new century. *Nursing Science Quarterly, 13*(1), 37-44.

King, I. M. (1987). King's theory of goal attainment. In R. Parse (Ed.). *Nursing science: Major paradigms, theories, and critiques.* Philadelphia: W. B Saunders.

Krueger, R. A. (1998a). *Moderating focus groups: Focus group kit 4*. Thousand Oaks, CA: Sage Publications.

Krueger, R. A. (1998b). *Developing questions for focus groups: Focus group kit 3*. Thousand Oaks, CA: Sage Publications.

Krueger, R. A. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Leary, D. E. (2009). Between Peirce (1878) and James 1898): G. Stanley Hall, the origins of pragmatism, and the history of psychology. *Journal of the History of the Behavioural Sciences, 45*(1), 5-20.

Leners, D. W., Roehrs, C., & Piccone, A. V. (2005). Tracking the development of professional values in undergraduate nursing students. *Journal of Nursing Education, 45*(12), 504-511.

Levett-Jones, T., Lathlean, J., Higgins, I., & McMillan, M. (2009). Staff – student relationships and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing, 65*(2), 316-324.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (pp. 163-188). Beverly Hills, CA: Sage.

Mantzoukas, S. (2005). The inclusion of bias in reflective and reflexive research. A necessary prerequisite for securing validity. *Journal of Research in Nursing, 10*(3), 279-295.

Marck, P. (1990). Therapeutic reciprocity: A caring phenomenon. *Advances in Nursing Science, 13*(1), 49-59.

McCallin, A. M. (2003). Designing a grounded theory study: Some practicalities. *Nursing in Critical Care, 8*(5), 203-208.

McCann, T. V., & Clark, E. (2003a). Grounded theory in nursing research: Part 1 – Methodology. *Nurse Researcher, 11*(2), 29-39.

McCann, T. V., & Clark, E. (2003b). Grounded theory in nursing research: Part 3 – Application. *Nurse Researcher, 11*(2), 29-39.

McEwen, M., & Wills, E. M. (2007). Theoretical basis for nursing (2nd ed.). Philadelphia: Lippincott Williams & Wilkins.

McGurk, V. (2008). Practice development within a neonatal intensive care unit: Innovation or expectation. *Journal of Neonatal Nursing, 14*(2), 52-55.

McKinlay, A., & Cowan, S. (2003). Student nurses' attitudes towards working with older patients. *Journal of Advanced Nursing, 43*(3), 298-309.

Meleis, A. I. (2007). *Theoretical nursing: Development and progress* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Meleis, A. I. (2012). *Theoretical nursing: Development and progress* (5th ed.). Philadelphia: Wolters Kluwer Heakth - Lippincott Williams & Wilkins.

Merriam-Webster. (2009). *Merriam-Webster on-line dictionary*. Retrieved from: http://www.merriam-webster.com/

Merriam-Webster. (2011). *Merriam-Webster on-line dictionary*. Retrieved from: http://www.merriam-webster.com/

Merriam-Webster. (2012). *Merriam-Webster on-line dictionary*. Retrieved from: http://www.merriam-webster.com/

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source* (2nd ed.). Thousand Oaks, CA: Sage.

Ministry of Health & Long-term Care. (2007). *Health outcomes for better information and care*. Toronto: Queen's Printer for Ontario.

Mitchell, G. J., & Bournes, D. A. (2010). Human becoming. In M. R. Alligood, & A. M. Tomey (7th ed.), *Nursing theorists and their work* (pp. 503-535). Maryland Heights, MI: Mosby Elsevier.

Miner-Williams, D. (2007). Connectedness in the nurse-patient relationship: A grounded theory study. *Issues in Mental Health Nursing, 28*, 1215-1234.

Montgomery, P. & Bailey, P. H. (2007). Field notes and theoretical memos in grounded theory. *Western Journal of Nursing Research, 29*(1), 65-79.

Morgan, D. L. (1998). *Planning focus groups: Focus group kit 2*. Thousand Oaks: Sage Publications.

Morgan, S., & Sanggaran, R. (1997). Client-centred approach to student nurse education in mental health practicum: An inquiry. *Journal of Psychiatric and Mental Health Nursing, 4*, 423-434.

Morrison, P., & Burnard, P. (1989). Students' and trained nurses' perceptions of their own interpersonal skills: A report and comparison. *Journal of Advanced Nursing, 14*, 321-329.

Morse, J. M. (1994). Designing funded qualitative research. In N. Denzin & Y. Lincoln (Eds.). *Handbook of qualitative research* (pp. 1-15). Thousand Oaks, CA: Sage Publications.

Morse, J. M. (1995). Editorial: The significance of saturation. *Qualitative Health Research, 5*(2), 147-149.

Morse, J. M. (2012). *Qualitative health research: Creating a new discipline.* Walnut Creek, CA: Left Coast Press.

Morse, J. M., & Field, P. (1995). *Qualitative research methods for health professionals* (2nd ed.). London: Sage.

Morse, J. M., Stern, P. N., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A. E. (2009). Developing grounded theory: the second generation. Walnut Creek, CA: Left Coast Press.

Moscaritolo, L. M. (2009). Interventional strategies to decrease nursing student anxiety in the clinical environment. *Journal of Nursing Education, 48*(1), 17-23.

Myrick, F. (1998). *Preceptorship and critical thinking in nursing education* (Doctoral dissertation). Retrieved from University of Alberta (Canada). (NQ34815)

Naef, R. (2006). Bearing witness: A moral way of engaging in the nurse-person relationship. *Nursing Philosophy, 7*, 146-156.

Nelson, S. (2012). The lost path to emancipatory practice: Towards a history of reflective practice in nursing. *Nursing Philosophy, 13*, 202-213.

Neuman, B. (1982). *The Neuman systems model: Application to nursing education and practice.* Norwalk, CT: Appleton-Century-Crofts.

Neuman, B. (1995). *The Neuman Systems Model* (3rd ed.). East Norwalk, CT: Appleton & Lange.

Newman, M. A. (2002). The pattern that connects. *Advances in Nursing Science, 24*(3), 1-7.

Newman, M. (2007). The power of one: Confidence in our evolving future. *Nursing Science Quarterly, 20,* 203-204.

Newman, M. A., Sime, A. M., & Corcoran-Perry (1991). Focus of the discipline of nursing. *Advances in Nursing Science, 14*(1), 1-6.

Newman, M. A., Smith, M. C., Pharris, M. D., & Jones, D. (2008). The focus of the discipline revisited. *Advances in Nursing Science, 31*(1), E16-E27.

Nielsen, K., Randall, R., Yarker, J., & Brenner, S. O. (2008). The effects of transformational leadership on followers' perceived work characteristics and psychological well-being: A longitudinal study. *Work and Stress, 22*(1), 16-32.

Nix, J., & Dillon, K. (1986). Short-term nursing therapy: A conceptual model for in-patient psychiatric care. *Hospital and Community Psychiatry, 37*(5), 493-496.

Nunkoosing, K. (2005). The problems with interviews. *Qualitative Health Research, 15*(5), 698-706.

Orland-Barak, L., & Wilhelem, D. (2005). Novices in clinical practice settings: Student nurses stories of learning the practice of nursing. *Nursing Education Today, 25*, 455-464.

Orlando, I. (1961). *The dynamic nurse-patient relationship: Function, process and principles.* New York: Putnam.

Oxford University Press. (2005). *Oxford Canadian dictionary of current English (Ed.).* Don Mills, ON: Author.

Parse, R. R. (1996). The human becoming theory: Challenges in practice and research. *Nursing Science Quarterly*, *9*(2), 55-60.

Parse, R. R. (2010). Human dignity: A humanbecoming ethical phenomenon. *Nursing Science Quarterly*, *23*(3), 257-262.

Paterson, J. G., & Zderad, L. T. (1976). *Humanistic nursing.* New York: John Wiley & Sons.

Paterson, J. G., & Zderad, L. T. (1988). *Humanistic nursing.* New York: National League for Nursing.

Pearcey, P., & Draper, P. (2008). Exploring clinical nursing experiences: Listening to student nurses. *Nurse Education Today*, *28*, 595-601.

Pearcey, P. A., & Elliott, B. E. (2004). Student impressions of clinical teaching. *Nurse Education Today, 24*, 382-387.

Peirce, A. G. (1991). Preceptorial students' view of their clinical experience. *Journal of Nursing Education*, *30*(6), 244-250.

Peplau, H. E. (1952/1988). *Interpersonal relations in nursing.* New York: Palgrave Macmillan.

Peplau, H. E. (1963). Interpersonal relations and the process of adaptation. *Nursing Science Quarterly, 3,* 272-279.

Peplau, H. E. (1991). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing.* New York: Springer Publishing Company.

Peplau, H. E. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. *Nursing Science Quarterly, 5*(1), 13-18.

Peplau, H. E. (1994). Quality of life: An interpersonal perspective. *Nursing Science Quarterly, 7*(1), 10-15.

Perry, B. (2009). Role modeling excellence in clinical nursing practice. *Nurse Education in Practice, 9,* 36-44.

Pettegrew, L., & Turkat, I. (1986). How patients communicate about their illness. *Human Communication Research, 12,* 376-394.

Picard, C. (1997). Embodied soul: The focus for nursing praxis. *Journal of Holistic Nursing, 15*(1), 41-53.

Phillips-Salimi, C. R., Haase, J. E., & Kooken, W. C. (2012). Connectedness in the context of patient-provider relationships: A concept analysis. *Journal of Advanced Nursing, 68*(1), 230-245.

Plummer, K. (1996). Symbolic interactionism in the twentieth century: The rise of empirical social theory. In B. Turner (Ed.), *The Blackwell companion to social theory* (pp. 223-251). Cambridge, UK: Blackwell.

Pound, P., & Ebrahim, S. (2000). Rhetoric and reality in stroke patient care. *Social Science and Medicine, 51*(10), 1439-1446.

Price, A., & Price, B. (2009). Role modeling practice with students on clinical placements. *Nursing Standard, 24*(11), 51-56.

Ramey, S. L., & Bunkers, S. S. (2006). Teaching the abyss: Living the art-science of nursing. *Nursing Science Quarterly, 19*(4), 311-315.

Ranheim, A., Karner, A., Arman, M., Rehnsfeldt, A. W., & Bertero, C. (2010). Embodied reflection in practice – 'Touching the core of caring'. *International Journal of Nursing Practice, 16*, 241-247.

Rask, M., & Brunt, D. (2007). Verbal and social interactions in the nurse-patient relationship in forensic psychiatric nursing care: A model and its philosophical and theoretical foundation. *Nursing Inquiry, 14*(2), 169-176.

Raychel, L. Y. F. (2007). Reflection on how assessment practices in the baccalaureate course affected the way I practice. *Singapore Nursing Journal, 34*(4), 28-35.

Reed, P. G., & Runquist, J. J. (2007). Reformation of a methodological concept in grounded theory. *Nursing Science Quarterly, 20*(2), 118-122.

Registered Nurses' Association of Ontario. (2002, revised 2006). *Establishing therapeutic relationships*. Toronto: Author.

Registered Nurses' Association of Ontario. (2006). *Client centered care.* Toronto: Author.

Richards, L. & Morse, J. M. (2007). *Readme first for a user's guide to qualitative methods* (2nd ed.). Thousand Oaks, CA: Sage.

Rogers, C. R. (1959). The essence of psychotherapy: A client-centered view. *Annals of Psychotherapy, 1,* 51-57.

Roy, C. (1991). *The Roy adaptation model: The definitive statement*. Norwalk, CT: Appleton & Lange.

Rubin, H. J., & Rubin, I. S. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Russell, C. (1994). Elder care recipients' insight into their caregivers: 'Beware the stone-face elephant!' *Geriatric Nursing, 15*, 308-312.

Russell, C. (1996). Elder care recipients' care-seeking process. *Western Journal of Nursing Research, 18*, 43-62.

Scanlon, A. (2006). Psychiatric nurses perceptions of the constituents of the therapeutic relationship: A grounded theory study. *Journal of Psychiatric and Mental Health Nursing, 13*, 319-329.

Schreiber, R. S. & Stern, P. N. (2001). *Using grounded theory in nursing*. New York: Springer.

Schubert, P. (1989). *Mutual connectedness: Holistic nursing practice under varying conditions of intimacy.* Ann Arbor, MI: University Microfilms International.

Sellman, D. (2007). Trusting patients, trusting nurses. *Nursing Philosophy, 8*(1), 28-36.

Shattell, M. (2004). Nurse-patient interaction: A review of the literature. *Journal of Clinical Nursing, 13*, 714-722.

Shellman, J. (2006). "Making a connection": BSN students' perceptions of their reminiscence experiences with older adults. *Journal of Nursing Education, 45*(12), 497-503.

Shields, E. (1995). Reflection and learning in student nurses. *Nurse Education Today, 15*, 452-458.

Sinnema, J. (2009, November 26). *Health board, nurses tangle over plan: Dispute centres on CEO Stephen Duckett's comments on number of new RNs to be hired* (pp. B3). Edmonton, AB: Edmonton Journal.

Stewart, D. W., & Shamdasani, P. N. (1990). *Focus groups: Theory and practice*. Newbury Park, CA: Sage Publications.

Strauss, A., & Corbin, J. (1998). *Basic of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Suikkala, A., & Leino-Kilpi, H. (2001). Nursing student-patient relationship: A review of the literature from 1984-1998. *Journal of Advanced Nursing, 33*(1), 42-50.

Suikkala, A., & Leino-Kilpi, H. (2005). Nursing student-patient relationship: Experiences of students and patients. *Nurse Education Today, 25*, 344-354.

Suikkala, A., Leino-Kilpi, H., & Katajisto, J. (2008a). Nursing student-patient relationships: A descriptive study of students' and patients' views. Retrieved October 19, 2008, from: http://www.bepress.com/ijnes/vol5/iss1/art15.

Suikkala, A., Leino-Kilpi, H., & Katajisto, J. (2008b). Factors related to the nursing student-patient relationship: The students' perspective. *Nurse Education Today, 28,* 539-549.

Sullivan, H. S. (1953). *The interpersonal theory of psychology*. New York: Norton.

Sumner, J. (2010). Reflection and moral maturity in a nurse's caring practice: A critical perspective. *Nursing Philosophy, 11*, 159-169.

Suominen, T., Leino-Kilpi, H., & Laippala, P. (1995). Who provides support and how: Breast cancer patients and nurses evaluate patient support. *Cancer Nursing, 18*(4), 278-285.

Sustrik, J., & Craik, K. (2009). *Formal complaint under the code of conduct.* Edmonton, AB: United Nurses of Alberta.

Tarlier, D. S. (2004). Beyond caring: The moral and ethical bases of responsive nurse-patient relationships. *Nursing Philosophy*, 5, 230-241.

Thorne, S. E., & Robinson, C. A. (1988). Reciprocal trust in health care relationships. *Journal of Advanced Nursing, 13*, 782-789.

Thorsteinsson, L. (2002). The quality of nursing care as perceived by individuals with chronic illnesses: The magical touch of nursing. *Journal of Clinical Nursing, 11*, 32-40.

Travelbee, J. (1966). *Interpersonal aspects of nursing.* Philadelphia: F. A. Davis.

Travelbee, J. (1971). *Interpersonal aspects of nursing*. Philadelphia: F. A. Davis.

Tuckett, A. G. (2007). Stepping across the line: Information sharing, truth telling, and the role of the personal carer in the Australian nursing home. *Qualitative Health Research, 17*, 489-500.

Tudor, G. E. (1952). A sociopsychiatric nursing approach to intervention in a problem of mutual withdrawal on a mental hospital ward. *Perspectives in Psychiatric Care, 8*(1), 11-35.

Tuohy, D. (2003). Student nurse-older person communication. *Nurse Education Today, 23*, 19- 26.

Turkel, M. C., & Ray, M. A. (2010). Relational complexity: A theory of the nurse-patient relationship within an economic context. *Nursing Science Quarterly, 13*(4), 307-313.

Twerski, R. F. (2008). Sensitivity training (part 1). Http://www.aish.com/family/rebbitzen/Sensitivity_Training.asp.

Vanhanen, L., & Janhonen, S. (2000). Changes in students' orientations to nursing during nursing education. *Nurse Education Today, 30*, 654-661.

Walker, D., & Myrick, F. (2006). Grounded theory: An exploration of process and procedure. *Qualitative Health Research, 16*(4), 547-559.

Waters, S. K., Cross, D. S., Runions, K. (2009). Social and ecological structures supporting adolescent connectedness to school: A theoretical model. *Journal of School Health, 79*, 516-524.

Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston, MA: Little Brown & Co.

Watson, J. (1999). Aesthetic expressions of caring: Private psalms – surrendering to the sacred. Personal professional reflections on caring and healing. *International Journal of Human Caring, 3*(3), 34.

Watson, J. (2001). Jean Watson: Theory of human caring. In M. E. Parker (Ed.), *Nursing theories and nursing practice* (pp. 343-354). Philadelphia: F. A. Davis.

Watson, J. (2007). Watson's theory of human caring and subjective living experiences: Carative factors/*caritas processes* as a disciplinary guide to the professional practice of nursing. *Texto & Contexto – Enfermagem, 16*(1). Retrieved from: http://dx.doi.org/10.1590/S0104-07072007000100016.

Watson, J., & Smith, M. C. (2002). Caring science and the science of unitary human beings: A trans-theoretical discourse for nursing knowledge development. *Journal of Advanced Nursing, 37*(5), 452-461.

Welch, D., & Wellard, S. (2005). The phenomenon of presence within contemporary nursing practice: A literature review. *The Australian Journal of Holistic Nursing, 12*(1), 4-10.

Wiedenbach, E., & Falls, C. E. (1978). *Communication: Key to effective nursing.* New York: Tiresias Press.

Willis, D. G., Grace, P. J., & Roy, C. (2008). A central unifying focus for the discipline: Facilitating humanization, meaning, choice, quality of life, and healing in living and dying. *Advances in Nursing Science, 31*(1), E28-E40.

Appendix A
Request for Letter of Permission

H. Kathleen R. White-Williams
5 Shirley Court, Box 316, Thornbury, ON N0H 2P0
RES: 780-477-4058 (Alberta) BUS: 780-492-6317 RES: 519-599-6782 (Ontario)
hazelw@ualberta.ca

September 4th, 2009

Dr. Katherine Moore
Vice Dean
Faculty of Nursing
Clinical Sciences Building, 3 – 129B
University of Alberta
Edmonton, AB T6G 2G3

Dear Dr. Moore,

My name is Kathleen White-Williams and I am a Doctoral Student with the Faculty of Nursing. I am requesting a letter of support to approach students and clinical nursing faculty in the fourth year of the undergraduate program to request their permission to be in my dissertation research study.

My PhD Supervisors are Drs. Beverly Williams and Rene Day.

Study Title: "Senior Nursing Student-Patient Connection: Student and Clinical Nursing Faculty Perceptions "

Research Purpose: While we know a great deal about student and nurse-patient relationships, we do not know much about the process of 'connection". This research will add depth of knowledge to our understanding and will be valuable in shaping future nursing education and continuing competence in nursing practice.

Research Questions: The following research questions will guide this study:

1. How do senior nursing students describe their connection with patients?
    a. What is the process(es) of connection in the senior nursing student-patient relationship?
    b. What factors influence the connection?
2. How do clinical nursing faculty describe the senior student-patient connection?
    a. What are the dimensions of this connection?
    b. What factors influence the connection?

Methodology: Qualitative, Glaserian Grounded Theory method

Sampling:

- 4th year nursing students (enrolled in N491in Fall term 2009)
- Clinical Nursing Faculty currently teaching N491. I am also requesting permission to recruit clinical nursing faculty members who have taught this course within the last five years if my recruitment numbers are low.

Data Collection:

- I anticipate doing 60 minute single interviews with about 20 to 30 students in NURS 491.
- I will conduct one 60 minute focus group with approximately 10 to 12 clinical nursing faculty.
- Individual interviews and the focus group session will take place in a designated office/room in the Faculty of Nursing .

Data Analysis: Constant Comparative Analysis technique.

Intended Results: I anticipate developing a theory grounded in data about the process of connection within the senior nursing student-patient relationship. I expect this research to add depth of knowledge to our understanding and to be valuable in informing future nursing education and continuing competence in nursing practice.

Thank you in advance for your consideration of my request, and I look forward to your letter of support for this important work.

Sincerely,

H. Kathleen R. White-Williams MN, RN, PhD (c)

Appendix B

Letter of Permission

UNIVERSITY OF ALBERTA
Faculty of Nursing
Office of the Dean

3–129 Clinical Sciences Building
Edmonton, Alberta, Canada T6G 2G3
Deans_office@nurs@ualberta.ca
www.uofaweb.ualberta.ca/nursing
Tel: 780.492.6236
Fax: 780.492.6029

September 15, 2009

H. Kathleen R. White-Williams, MN, RN, PhD(c)
Faculty of Nursing
3rd Floor, Clinical Sciences Building
Edmonton, AB T6G 2G3

Dear Ms. White-Williams:

Thank you for your request to invite 4th year Nursing Students and Clinical Nursing Faculty to participate in your study on 'connection' of nursing students and their patients. On behalf of the Dean of Nursing, Dr. Anita Molzahn, I support the study in principle and will endeavour to assist you in reaching potential participants by sending an email invitation to them. It is understood that you will not be provided with direct contact information for our students.

Sincerely,

Katherine N. Moore PhD RN CCCN
Professor & Vice Dean

cc B. Williams
R. Day

Appendix C

Health Research Ethics Board

308 Campus Tower
University of Alberta, Edmonton, AB T6G 1K8
p. 780.492.9724 (Biomedical Panel)
p. 780.492.0302 (Health Panel)
p. 780.492.0459
p. 780.492.0839
f. 780.492.7808

APPROVAL FORM

Date: September 29, 2009

Principal Investigator:	Rene Day
Study ID:	Pro00008484
Study Title:	Senior Nursing Student-Patient Connection: Student and Clinical Nursing Faculty Perceptions
Approval Expiry Date:	September 28, 2010

Thank you for submitting the above study to the Health Research Ethics Board (Health Panel). Your application, along with revisions submitted September 29, 2009, has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Health Research Ethics Board does not encompass authorization to access the patients, staff or resources of Capital Health or other local health care institutions for the purposes of the research. Enquiries regarding Capital Health administrative approval, and operational approval for areas impacted by the research, should be directed to the Capital Health Regional Research Administration office, #1800 College Plaza, phone (780) 407-1372.

Sincerely,

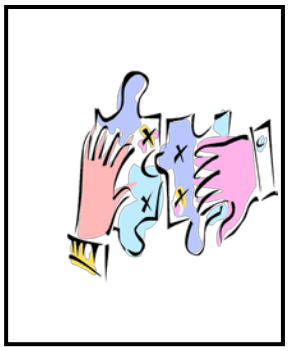
Glenn Griener, Ph.D.
Chair, Health Research Ethics Board (Health Panel)

Note: This correspondence includes an electronic signature (validation and approval via an online system).

UNIVERSITY OF ALBERTA Alberta Health Services Covenant Health

Appendix D

Nursing Student Information Script



Hello. My name is Kathleen White-Williams and I am a Doctoral Student in the Faculty of Nursing at the University of Alberta. I am also a nursing professor at a large educational institution in southern Ontario.

Drs. Beverly Williams and Rene Day are supervising this study.

I am interested in developing knowledge about the process of nursing student-patient connection.

Clinical nursing faculty and 4th year nursing students are invited to participate in this research study exploring the process of "Nursing Student-Patient Connection".

Process:
If you agree to be in the study, you will be interviewed by me in a designated office in the Faculty of Nursing. Your interview will be about one hour in duration at a time mutually agreeable to you and I.

The interview will be audio taped and transcribed verbatim. A summary of your interview will be e-mailed to you. I will contact you by telephone to ask you for your response to the summary.

Contact:
If you would like more information and would like to be part of this study, please contact Kathleen at:

(Hazel) Kathleen White-Williams
Phone: 780-492-6317
E-mail: hazelw@ualberta.ca

Hazel Kathleen White-Williams
Phone: 780-492-6317
e-mail: hazelw@ualberta.ca

"Nursing Student-Patient Connection" Study

Appendix E

Nursing Student Information for Informed Consent

Study Title: Senior Nursing Student-Patient Connection: Student and Clinical Nursing Faculty Perceptions.
Investigator: (Hazel) Kathleen White-Williams MN, RN, Doctoral Student
Phone: 780-492-6317
E-mail: hazelw@ualberta.ca
Sponsor: Faculty of Nursing, University of Alberta, Edmonton, Alberta

Supervisors:
Dr. Beverly Williams, Associate Professor, Faculty of Nursing, University of Alberta, 6-126F Clinical Sciences Building, Edmonton, Alberta, T6G 2G3
Phone: (780) 492-8054, FAX: (780) 492-2551, E-mail: beverly.williams@ualberta.ca
Dr. Rene Day, Professor Emeritus, Faculty of Nursing, University of Alberta, 6-127 Clinical Sciences Building, Edmonton, Alberta, T6G 2G3
Phone: (780) 492-6481, FAX: (780) 492-2551, E-mail: rene.day@ualberta.ca

Study Background: I am a nursing professor at Humber College Institute of Technology and Advanced Learning in Toronto, Ontario. I am working on a PhD degree in nursing from the University of Alberta in Edmonton, Alberta. I want to learn more about the process of the nursing student-patient connection.

Study Purpose: The purpose of this study is to develop knowledge about the process of nursing student-patient connection.

Study Procedures: I would like to talk with you about how you connect with your patients. Our conversation will take place in the Faculty of Nursing. Our conversation will last about one hour. I will send you a summary of what I learned from my conversation with you. I will then telephone/e-mail you to ask about your response to the summary.

I will audio tape all of the conversation, and our conversation will be transcribed verbatim. My typist, co-supervisors and I will be the only people to listen to the tapes. The transcription may be seen by my co-supervisors and research committee. To protect your identity, I will ask you to choose a pseudonym, and this pseudonym will be used to identify tapes and transcripts of the tapes. In the research report, a pseudonym will identify scripts. The tapes, transcripts, and research notes will be kept in a locked file cabinet, and will be kept for a minimum of seven years after the research is complete.

I will ask you to sign a consent form and this form will also be kept in a locked file cabinet separate from the tapes, transcripts, and research notes, and the consent forms will be kept for at least seven years. Data may be used for another

study in the future. I will receive approval from the appropriate ethics review committee before doing further analysis with this data. Information and findings from this study will be published and presented at conferences, and your name or any other identifying information will not be used.

Possible Benefits: There are no known benefits from being in this study.

Possible Risks: There are no known risks from being in this study.

Voluntary Participation: You are free to participate or not in this study, and you are free to withdraw from the research study at any time and your status as a student will not be affected in any way. You do not have to answer any questions or talk about anything in the interviews if you do not want to, and you can ask to have the tape recording stopped at any time. Clinical nursing faculty will know that a study is being conducted. However, I will be the only person who will know that you are in the study.

Contact Names and Telephone Numbers:
If you have any questions about any part of this study, you may contact me or my supervisors at the telephone or E-mails above. If you have concerns about the study, you may contact Dr. Christine Newburn-Cook, Associate Dean Research, Faculty of Nursing, University of Alberta, (780) 492-5929. Dr. Newburn-Cook is not part of this study.

Appendix F

Nursing Student - Initial Contact Form

Name: _____ **Code #: _____**

Date: _____

Telephone numbers: (home)

(work)

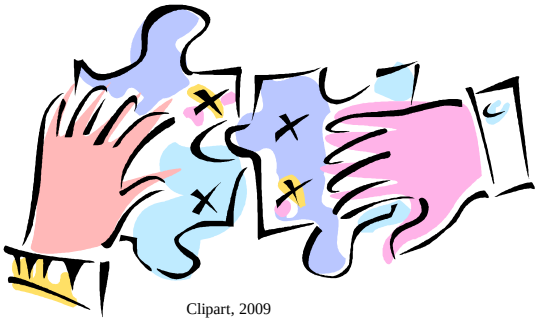
(cell)

Fax:

E-mail address:

Appendix G

An Opportunity to Participate in Nursing Research



Clipart, 2009

Only one hour of your time!

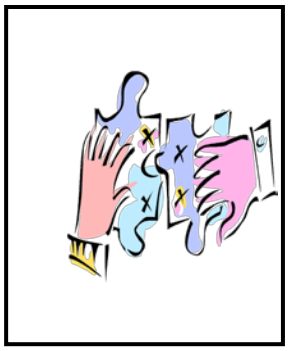
An exciting opportunity for NURS 491 students, from the University of Alberta, to participate in a research study exploring the process of "Student-Patient Connection".

Principal Investigator: Kathleen White-Williams
Doctoral Student
Faculty of Nursing, University of Alberta

Co-Supervisors: Dr. Beverly Williams, Associate Professor
Dr. Rene Day, Professor Emeritus
ersity of Alberta

Please contact me at:
(Hazel) Kathleen White-Williams
Phone: 780-492-6317
E-mail: hazelw@ualberta.ca

Appendix H
Faculty Focus Group Script



Hello. My name is Kathleen White-Williams and I am a Doctoral Student in the Faculty of Nursing at the University of Alberta. I am also a nursing professor at a large educational institution in southern Ontario.

Drs. Beverly Williams and Rene Day are supervising this study.

I am interested in developing knowledge about the process of nursing student-patient connection.

Clinical nursing faculty and 4th year nursing students are invited to participate in this research study exploring the process of "Nursing Student-Patient Connection".

Process:
If you agree to be in the study, you will be participating in a focus group interview conducted by me in a designated office in the Faculty of Nursing. The focus group interview will be about sixty minutes in duration at a time mutually agreeable to the participants and me.

The interview will be audio taped and transcribed verbatim. A summary of the focus group interview will be e-mailed to you. I will contact you by telephone to ask you for your response to the summary.

Contact:
If you would like more information and would like to be part of this study, please contact Kathleen at:

(Hazel) Kathleen White-Williams
Phone: 780-492-6317
E-mail: hazelw@ualberta.ca

Appendix I

Clinical Nursing Faculty Information for Informed Consent

Study Title: Senior Nursing Student-Patient Connection: Student and Clinical Nursing Faculty Perceptions.
Investigator: Kathleen White-Williams MN, RN, Doctoral Student
Phone: 780-492-6317
E-mail: hazelw@ualberta.ca
Sponsor: Faculty of Nursing, University of Alberta, Edmonton, Alberta
Supervisors:
Dr. Beverly Williams, Associate Professor, Faculty of Nursing, University of Alberta, 6-126F Clinical Sciences Building, Edmonton, Alberta, T6G 2G3
Phone: (780) 492-8054, FAX: (780) 492-2551, E-mail: beverly.williams@ualberta.ca
Dr. Rene Day, Professor Emeritus, Faculty of Nursing, University of Alberta, 6-127 Clinical Sciences Building, Edmonton, Alberta, T6G 2G3
Phone: (780) 492-6481, FAX: (780) 492-2551, E-mail: rene.day@ualberta.ca

Study Background: I am a nursing professor at Humber College Institute of Technology and Advanced Learning in Toronto, Ontario. I am working on a PhD degree in nursing from the University of Alberta in Edmonton, Alberta. I am interested in 4th year nursing student-patient connection and I want to learn more about the process of connecting. I am interested in faculty members' perceptions of how students connect with patients and also of times when you thought that a student may not have connected with a patient. I will also ask you for information about your background, for example, the number of years you have been in nursing education.

Study Purpose: The purpose of this study is to develop knowledge about the process of nursing student-patient connection.

Study Procedures: I would like to meet with you in a focus group session in a designated room in the Faculty of Nursing, Clinical Sciences Building. The focus group will last about 90 minutes. At the end of the session, I will give a brief summary of key points and will ask for your confirmation of the ideas. Later I will send you a summary of what I learned from the focus group. I will then telephone/e-mail you to ask about your response to the summary.

I will audio tape the entire focus group session and our conversation will be transcribed verbatim. My typist and I will be the only people to listen to the tapes. The transcription may be seen by my co-supervisors and research committee. To protect your identity, I will ask you to choose a pseudonym, and this pseudonym will be used to identify tapes and transcripts of the tapes. In the research report, a pseudonym will identify scripts. The tapes, transcripts, and research notes will be

kept in a locked file cabinet, and will be kept for a minimum of seven years after the research is complete.

I will ask you to sign a consent form and the form will also be kept in a locked file cabinet separate from the tapes, transcripts, and research notes, and the consent forms will be kept for at least seven years. Data may be used for another study in the future. I will need to receive approval from the appropriate ethics review committee before doing further analysis with this data. Information and findings from this study will be published and presented at conferences, and your name or any other identifying information will not be used.

Possible Benefits: There are no known benefits from being in this study.

Possible Risks: There are no known risks from being in this study.

Voluntary Participation: You are free to participate or not in this study, and you are free to withdraw from the research study at any time and your status as a faculty member will not be affected in any way. You do not have to answer any questions or talk about anything in the focus group if you do not want to. At the end of the focus group I will turn off the tape recorder. Nursing students will know that a study is being conducted. The researcher will not disclose who is in the focus group.

Contact Names and Telephone Numbers:
If you have any questions about any part of this study, you may contact me or my supervisors at the telephone numbers or E-mail addresses listed above. If you have concerns about the study, you may contact Dr. Christine Newburn-Cook, Associate Dean Research, Faculty of Nursing, University of Alberta, (780) 492-5929. Dr. Newburn-Cook is not part of this study.

Appendix J

Clinical Nursing Faculty - Initial Contact Form

Name: _____ Code #: _____

Date: _____

Contact numbers: (home) _____

(work) _____

(cell) _____

(fax) _____

E-mail address: _____

Demographic Information

Gender: F ( ) M ( )

Highest Educational Preparation:

( ) BScN

( ) Master (Nursing)

( ) Master (Education)

( ) Master (Other) _____

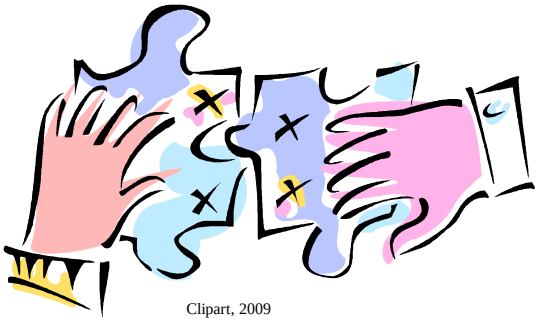
Job Title (in academe): _____

Years in Nursing Education: _____

Years in Nursing Practice: _____ Currently Practicing: ( ) Yes ( ) No

Appendix K

An Opportunity to Participate in Nursing Research



Clipart, 2009

Only one hour of your time!

An exciting opportunity for NURS 491 clinical nursing faculty, from the University of Alberta, to participate in a research study exploring the process of "Student-Patient Connection".

Principal Investigator: Kathleen White-Williams
Doctoral Student
Faculty of Nursing, University of Alberta

Co-Supervisors: Dr. Beverly Williams, Associate Professor
Dr. Rene Day, Professor Emeritus
Faculty of Nursing, University of Alberta

Please contact me at:
(Hazel) Kathleen White-Williams
Phone: 780-492-6317
E-mail: hazelw@ualberta.ca

Appendix L
Nursing Student Informed Consent Form

Part 1 (to be completed by the Principal Investigator):

Title of Project: Senior Nursing Student-Patient Connection

Principal Investigator(s):	Phone Number(s):
Kathleen White-Williams	780-492-6317

Co-Investigator(s):	Contact Names:	Phone Number(s):
Dr. Beverly Williams		780-492-8054
Dr. Rene Day		780-492-6481

Part 2 (to be completed by the research subject):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand that the interview will be tape recorded?	☐	☐
Do you understand the risks and benefits involved in taking part in this study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your status as a student?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to the information you provided?	☐	☐

Who explained this study to you? _____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Participant _____

(Printed Name) _____

Date:_____

Signature of Witness _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix M

Nursing Student Interview Guide

Name: ---------- **Code #**

Introduction and check recorder is working:

Good morning!

I will explain the information letter in detail.

Before beginning the interview, I will have the participant read and sign the consent form and give the participant a copy of the information letter.

Process:

As you know, I am interested in exploring how nursing students connect with their patients. Can you tell me about a time when you felt really connected to your patient? What was it like? How did it feel? How did you know you were connected?

For you, is there a difference between connection and relationship?

You have indicated that you felt connected to ------ today. Can you tell me more about that?

Was the experience today similar or different from other experiences when you felt connected?

Have there been times when you did not feel that sense of connection with your patients? Can you tell me a bit more about that experience?

Note: subsequent questions will be developed based on responses from these questions.

Is there anything else you wish to add?

Now that the interview is over, I want to confirm that you are still willing to let me include your conversation in the study.

Conclusion:

Thank you for sharing your thoughts and ideas with me. If you want to change or add to the information you provided in the interview, please telephone me collect at 780-492-6317.

Appendix N

Nursing Student – Demographic Form

Name: _____ Code #: _____

Date: _____

Demographic Information

Age: ____

Gender: F ( ) M ( )

Describe your health related work experience (e.g. personal support worker, personal assistant):

1. Prior to entering the nursing program:

2. While enrolled in the nursing program (also include the number of hours you work per week):

Where did you **begin** your current nursing program

( ) University of Alberta ( ) Grant McEwan ( ) Other _____

Appendix O

Field Note Recording Form – Code: Sara

Descriptive Notes

These are the field notes for the interview that just happened for PRO00008484, Interview #010, October 29th, 2009. We began shortly after 0900 hours and we ended shortly before 1000 hours. In terms of the setting, we interviewed in a room in the Clinical Sciences Building. The interview room is bright with lots of artificial and natural light from one long vertical window. There is a nice ambient temperature that is manually controlled at about 22 degrees Celsius. The room is furnished with a sofa and large arm chair, both quite comfortable to sit in. The walls are painted a soft, pastel mauve. There are neutral pictures on four of the walls, and a standing lamp beside the sofa. There is a telephone on a small bookcase on the wall that is situated at right angles to the chair and sofa. There is a coffee table situated between the sofa and the large arm chair. The one end of the coffee table was used to place the recorder for this interview.

The participant stated she had just finished writing the medical-surgical examination, and then went to "Earl's" for lunch with a friend. Her friend accompanied her to this interview (the friend is the next booked interview). She came early to this appointment (was booked for 1100 hours). She looked quite good for just completing an exam, bright eyed, smile on face. We sat diagonally, that is kitty corner to each other, the participant on the sofa and I sat in the arm chair. The whole atmosphere was much more comfortable as with the last few interviews. We were about three feet apart and the tape recorder was placed in the middle of us on the coffee table. The participant was given a copy of the consent information and we reviewed the consent information in detail together. The participant was asked if she had any questions, and having none, she completed the consent and signed the consent. I indicated that there would be a demographic sheet to complete at the end of the interview. I explained the process of the interview, encouraged the participant to ask questions before, during and after the interview, and indicated that there are no right or wrong answers. I offered water and an apple which the participant declined. She confirmed that she was comfortable, and I asked if she was ready to begin. The participant confirmed that she was ready.
I checked to make sure the tape was recording. I reiterated that the study was about nursing students connecting with their patients. I also shared that some nurses connect with their patients and other nurses have more difficulty connecting with patients.

Interpretive Notes

The participant talked about connecting with her patients, and seemed to reinforce this throughout the interview. She emphasized the more connections the more fulfilling the relationship. This is a recurring 'notion' in these interviews. She seems to be making a distinction between connection and relationship. She also confirmed that there were times when she did not connect with her patients and gave an example of giving care only. Interesting how the same themes are coming out. I must explore this notion of different relationships….She also talked about role modeling and opportunities for the program. I must explore these two in more detail.

Appendix P

(Official letterhead)

(Date)
(Name and Address of Participant)

Thank you for accepting my invitation to attend the discussion about "Nursing Student-Patient Connection" in room ----, 6th floor, in the Faculty of Nursing, Clinical Sciences Building, on -----. The focus group session will begin at 10:00 a.m. and conclude at 11:30 a.m. Refreshments will be provided.

Because we will be a small group, the success and quality of our discussion is based on the interaction and cooperation of the people who attend. Since you have accepted my invitation, your attendance at the session is anticipated and will help in making the research project a success.

The discussion you will be attending will be a meeting of other clinical nursing faculty who are teaching the senior medical-nursing course. We will be discussing Nursing Student-Patient Connection and we would like to get your opinions on this subject.

If for some reason you are not able to attend, please call to let me know as soon as possible. Our number is xxx-xxx-xxxx.

I look forward to seeing you on ----------.

Sincerely,

Hazel White-Williams

Appendix Q

Clinical Nursing Faculty - Informed Consent Form

Part 1 (to be completed by the Principal Investigator):

Title of Project: Senior Nursing Student-Patient Connection

Principal Investigator(s):	Phone Number(s):
Kathleen White-Williams	780-492-6317

Co-Investigator(s):	Contact Names:	Phone Number(s):
Dr. Beverly Williams		780-492-8054
Dr Rene Day		780-492-6481

Part 2 (to be completed by the research subject):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand that the interview will be tape recorded?	☐	☐
Do you understand the risks and benefits involved in taking part in this study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your status as a student?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to the information you provided?	☐	☐

Who explained this study to you? _____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Participant _____

(Printed Name) _____

Date:_____

Signature of Witness _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix R

Group Agreement for Maintaining Confidentiality (Faculty)

This form is intended to further ensure confidentiality of data obtained during the research study on the experiences of clinical nursing faculty in relation to nursing student-patient connection.

Do you understand that this focus group interview will be recorded on audiotape? Yes No

Do you agree not to talk about information relating to this study or interview with anyone outside of your fellow focus group members and the researcher? Yes No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____
Signature of Research Participant Date Witness

_____ _____
Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator or Designee Date

Appendix S

Clinical Nursing Faculty – Focus Group Guide **Code #**

Check recorder is working.
Invite participants to have refreshments provided.

Script (adapted from Kreuger, 1994):

Good morning and welcome to our session today. Thank you for taking the time to join our discussion on nursing student-patient connection.

My name is Kathleen White-Williams and I am a Doctoral Candidate in the Faculty of Nursing here at the University. Also, I live in Ontario and I am a Nursing Professor in an undergraduate nursing program in a large urban centre. I would like to find out more about how Clinical Nursing Faculty feel about nursing student and patient connections. I have invited people who are currently teaching in the course NURS 491 and who taught this course within the last year to share their perceptions and ideas.

The participants in this discussion have certain things in common that are of particular interest to me. You are all clinical nursing faculty and have taught or are currently teaching the same nursing course. I am particularly interested in your views because other nursing faculty may have similar views.

Today we will be discussing your experiences and your opinions about nursing students connecting with their patients. There are no right or wrong answers, although there will be differing points of view. You are encouraged to share your point of view even if it differs from what others have said.

Before we begin, let me share some ground rules.

- This is strictly a research project.
- Please speak up.....only one person should talk at a time.
- We're tape recording the session as I do not want to miss any of your comments.
- If you do not want to be recorded you have permission to leave the session now.
- If several participants are talking at the same time, the tape recording will get muddled and I'll miss your comments.
- We will be on a first name basis today, and in the summary report no names will be attached to comments.
- You may be assured of complete confidentiality.
- Please keep in mind that I am just as interested in negative comments as positive comments, and sometimes the negative comments can be more enlightening.

Our session will last about 90 minutes. Let's begin! I've placed name cards on the table in front of you to help us remember each other's names. Let's go around the table one at a time. Tell us your name and how many times you have taught the NURS 491 course.

Focus Group Question Guide

Opening statement:

I am going to share an opening thought provoking statement with you. I would like you to think about this statement. Our discussion will be guided by a series of questions that are broadly related to the statement.

"I want you to think of a time in the past when you felt your students connected with the patients." PAUSE+++++

1. What do you see or look for when observing the student with a patient?

2. How do you identify "connection"?
    i. What do you think are the qualities of connection?

3. What do you do to assist students to connect?
    i. What do you do to assist students to connect with their patients?

4. How do you know when the student hasn't connected with their patient?
    i. Are there factors that lead to a connection with the patient?
    ii. Are there factors that prevent a connection with the patient?
    iii. What do you do if a student is having trouble connecting with the patient?

5. What expectations do you have of 4th year nursing students and connecting with patients?

I will provide a 2 to 3 minute summary of the discussion, and invite comments, amendments, or corrections. I will then turn off the recording equipment, indicate that the discussion is now complete, thank the participants for their contributions to the discussion, and ask one final question:

Do you think we've missed anything in the discussion?

Appendix T

Neutral Questions

What is this data a study of?

What category or what property of what category does this incident indicate?

What is actually happening in the data?

What is the basic social psychological process or social structural process that processes the main problem that makes life viable in the action scene?

(Glaser, 1992, p. 51)

Appendix U

Senior Nursing Student-Patient Connection – Memoing Recording Form– After Code Bobby

Developing Ideas, Hunches, Uncertainties, Feelings

Recurring themes…
Ok, so saying to me here again…that the therapeutic nurse-patient relationship is tasks and skills only…I sense that this is more of a reciprocal exchange than actually going deeper to develop a therapeutic relationship…perhaps I am wrong…need to feel this out further…

Students seem to be asking for more support with how to connect with patients…these are fourth year students…this is a little unsettling…need to be more intrusive with this one in the next interviews…re: role modelling,

Interpretation and Constructive Thoughts

Hmmm, just had the focus group interview yesterday…a few folks dominating the conversation…found out that one faculty member only does the skills and tasks with the students…Ok my! Perhaps my first theme here is on track!

Also, seems to be a disconnect between what the faculty are doing (role modeling behaviours) with the students and how the students interpret what the faculty do with them to encourage connection! Perhaps the faculty are not clearly articulating what they want the students to "do"…are students getting it?

On the emerging theory piece, so connection might be interacting, some kind of reciprocal exchange and feelings? Need to talk to Bev re: reciprocal exchange or reciprocity

Appendix V

Knowledge-Sharing Strategies

A. Writing (permanent knowledge-sharing products)

	Rationale
Publish:	
1. the findings in a peer reviewed nursing education journal that has a focus on research a. (e.g. International Journal of Nursing Education) 2. the entire article in the Journal of Qualitative Research	• Target a specific audience (e.g. researchers, nursing educators) • Access to all interested parties • Does not reach all audiences • Become outdated
In addition: 3. Main Message - 1 page – for each nursing faculty member (University of Alberta and Health Sciences, Nursing), and professional nursing practice settings (all clinical placements associated with our programs) to post in a prominent place	• Hence, use multiple strategies!!! Read on…
4. Executive Summary – 3 pages i. College & Association of Registered Nurses in Alberta ii. Registered Nurses' Association of Ontario iii. College of Nurses iv. Ontario Nurses' Association v. Registered Practical Nurses' Association of Ontario vi. Executive Assistant, Minister of Colleges and Universities, Ontario Government vii. Executive Assistant, Minister of Health, Ontario Government	• Specific information for targeted audiences (1:3:25 principle) • Specific one chosen tailored to decision-makers and broader audiences

5. <u>The Report</u> – 25 pages b) Faculty of Nursing, University of Alberta and UNB-Humber Collaborative Nursing Degree Program (Deans, Associate Deans, Directors, Program Co-ordinators, Curriculum Committee) c) Canadian Association Schools of Nursing (CASN) d) Canadian Nurses Association	**Rationale** • complete report – working document
<u>6.Media Advisory</u> a. for all conference, speaking engagements (please see section B)	• brief tip sheet • attract attention (assignment editors and news reporters) to upcoming events (e.g. RNAO Educational Conference)

B. Speaking **Rationale**

1. Conferences
    - i. Margaret Scott Wright Research Day, Edmonton, October 2013
    - ii. RNAO Nursing Education Conference, Toronto, November 2013
    - iii. Humber College ITAL Showcase, Toronto, May 2013
    - iv. Thinking Qualitatively Workshop Series, Edmonton, July 2013
    - v. UNB Nursing Research Day, New Brunswick, May 2013
    - vi. Community of UNB-Humber Nursing Faculty (UNB), December 2011

- Networking (e.g. face-to-face) for a number of diverse audiences who share an interest in this topic
- Need to look for creative funding to finance this (conference and attendance)

2. Lectures and Presentations
    - i. Guest lecturer – undergraduate research course (UNB-Humber; Faculty of Nursing, University of Alberta; Faculty of Nursing, Ryerson University)
    - ii. Guest presenter – Annual Continuing Education (Nursing) Dinner, CE Chang School, Ryerson University
    - iii. RNAO – Nursing Research Interest Group and Provincial Nurse Educators Interest Group

- Opportunity to share theoretical knowledge, implications of research
- Audience specific message
- key messages for topic

3. Meetings
    - i. Nursing Advisory Committees (all sites)
    - ii. Nursing Council Meetings (practice settings)

- meeting of people with common interests to share knowledge
- valuable insight into cultures in which each operates
- share each other's knowledge sharing needs

C. On-line

1. Webct sites - with asynchronous chat availability
    i. Faculty of Nursing, University of Alberta
    ii. UNB-Humber Collaborative Nursing Degree Program
    iii. Humber Research Initiative
    iv. faculty profiles (Dr. Beverly Williams, Dr. Rene Day, Kathleen White-Williams)

2. Google – to navigate to specific areas

3. On-line discussions
    i. establish an on-line Doctoral student discussion forum (start with Faculty of Nursing), an adjunct to the seminar dissertation course
    ii. establish a 'grounded theory' discussion forum

Rationale

- removes the valuable component of face-to-face interaction in knowledge sharing
- knowledge-sharing communities already established at these sites
- opportunity to get information "out there"; common source for "information seeking"
- interactive discussions, participants agree to take part in role of moderator
- would need to ensure "netiquette"