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FORMATION IN AN ACCELERATED NURSING PROGRAM: LEARNING EXISTENTIAL SKILLS OF NURSING PRACTICE

by

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DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Nursing

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

[redacted]

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By
Susan McNiesh

To my loving family: Charles, Justin, Lesley, and Lina

And to the memory of Susan Shulman who

felt privileged to take up the practice of nursing

Preface and Acknowledgements

This work and my formation as a researcher were guided and nurtured by many bright and kind souls. It is a fond exercise to trace the roots as well as the journey through my doctoral education so that I can acknowledge those that have been pivotal in this process. I came into nursing as a third career for the economic security it might provide. I landed early in the perinatal department at Watsonville Community Hospital and was privileged to work for many years with a very cohesive and caring group of nurses who wholeheartedly supported women's rights and an underserved population.

Susan Murphy, my adviser in the master's program at San Jose State University, opened up my thinking about the possibility of other ways of knowing beyond the dominant paradigm assumptive in scientific research. Susan was also the person who gently but insistently prodded me to continue my education in the doctoral program at UCSF.

I will have been at UCSF only a short three years. During that time my adviser, Patricia Benner, has amazed me with her insight and intellect. Early on Patricia frequently "dropped" philosophical book titles to read, and my early attempts at this reading made me feel swept up in an undertow. I learned early on to carry a tape recorder to our meetings and then transcribe and read and think over my notes at a later date. Our meetings always expanded my thinking to another level, and I now understand major portions of those philosophical texts. Patricia also gave me the very sage advice to take this time as a gift to myself and the immersion as researcher and scholar has been transformational.

I was fortunate to be part of a small Family Theory class taught by Kit Chesla early in my second year of study. Kit encouraged the group to configure our class papers

towards the eventual writing of our qualifying exam papers. Though a skeletal version, that paper did have "good bones" and became the basis of my qualifying theory paper. Since that time Kit has challenged, encouraged, and pushed me to do my best work. Kit has also provided practical and thoughtful advice on developing and managing a research project.

Garrett Chan has been an experienced guide in the practical aspects of doctoral education at UCSF. From the first time I met Garrett at a Brown Bag Forum he has provided sage and pragmatic advice on "getting through". He has given early advice on writing- the first such meeting happened at his house to start talking about my ideas for my qualifying papers. Garrett was always encouraging of my progress. His pragmatic support sometimes extended to emotional anchor as well.

Lisa Day was willing to take on much of the first reader tasks for my qualifying papers. Lisa's comments were thoughtful, intelligent, and instructive and her tone was always very encouraging. I appreciated Lisa's first comment when I notified her of the people on my committee: "this is going to be fun." I wouldn't exactly say it has been fun, though at times it has been deeply rewarding, typically exciting, and sometimes bordering on pleasurable. I have often felt I had phenomenally good luck to have four accomplished phenomenologists on my committee.

The only one to one conversation I ever had with Hubert Dreyfus was about the movie, The New World by director Terence Malick, also a phenomenologist. However, I had the opportunity to take three classes with Dr. Dreyfus (two on digital media) and I believe he is the finest lecturer I have ever experienced. He deeply opened up my understanding of the writing of both Merleau-Ponty and Heidegger.

Ruth Malone encouraged me to rewrite my theory qualifying paper for another publication. This came at a time when I had furiously been writing and didn't really think I could stand to confront that paper again. Another chance to be pushed along!

My small group in the Qualitative Series class, headed by Holly Kennedy and Maria Gudmundsdottir, provided many early forays into interpretive work. We inspired and encouraged each other. This group included Bonita Huiskes, Jackie Willets, Liana Hain, MK McKown, Candace Burton, Pra Tasanoa, Diana Lau, and Gina Intinerelli.

I cannot find the words to express the depth of my gratitude for the love, support, and pride of my family during my time at UCSF: my children, Justin and Lesley; my daughter in law, Lina; and my husband Charles. This gratitude goes especially to Charles because he lived with this dissertation, and through it, day by day.

I have been fortunate to receive generous funding from the Betty Irene Moore Foundation in the form of a fellowship while attending UCSF. I would also like to thank the UCSF Graduate Division for a research award. This award, and funding from the UCSF Century Club, helped defray the considerable cost of interview transcriptions.

Lastly, and most importantly, I thank the participants in my study. The intensity, physicality, and rigor of their program of study are well documented in this dissertation. It is a testament to their belief in furthering the profession that they were willing to give of hours of their time in the interest of furthering our understanding of their process of taking up nursing practice. They were honest, articulate, and thoughtful in their responses. I will miss our interactions.

Additional comment on the format of this dissertation:

Chapters Five and Six have been formatted as articles and will be submitted as manuscripts to nursing journals.

Abstract

FORMATION IN AN ACCELERATED PROGRAM: TAKING UP EXISTENTIAL SKILLS OF THE PRACTICE

Susan McNiesh

In response to increasing concerns over the national shortage of nurses, schools of nursing, public and private health funding agencies, and health care service organizations have joined forces to offer solutions to the increasing demand for nurses. One solution is to tap into a new population of potential students, those with undergraduate degrees in disciplines other than nursing. There has been little research on accelerated nursing programs and many schools have not yet tailored their curricula to meet the needs of this richly experienced group.

The goal of this qualitative research study was to articulate the background understanding of how students in an accelerated master's entry program experientially take up the practice of nursing. Specific aims included: What pivotal formative experiences do students identify as helping them develop and differentiate their clinical practice? How does "the press of the situation" affect the student's performance? How do previous life experiences, education, and career choices influence the experience of second degree students? What potential effects does condensing and accelerating the curriculum have on learning in second degree programs?

Data from clinical observations and a combination of small group and individual interviews (N=19) were analyzed using interpretive phenomenological methods. Two lines of inquiry were revealed. The first includes an articulation of the layering of factors that co-constitute to form the background of intensity in an accelerated program. A second line of inquiry articulates the pivotal and formative skills learned through the

independent care of a patient. By experiencing the responsibility and action from within the body and from within concrete situations the student is transformed and develops a new understanding that literally changes the individual's embodied ways of perceiving and orienting to the situation, as well as his or her skills and set to act.

This research extends the horizon of what can be seen of the background that grounds the taking up of nursing practice in accelerated learning environments. Further research could uncover additional aspects of this rich learning community including relationships among students, with clinical instructors, and with the nurses that facilitate the students' journey.

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CHAPTER ONE

Introduction

> It is because subjects do not, strictly speaking, know what they are doing that what they do has more meaning than they know. (Bourdieu, 1977, p. 79)

Background

In response to increasing concerns over the national shortage of nurses, schools of nursing, public and private health funding agencies, and health care service organizations have joined forces to problem solve and offer solutions to the increasing demand for nurses. One solution is to tap into a large new population of potential students, those with undergraduate or graduate degrees in a discipline other than nursing. A recent joint press release by the Robert Wood Johnson Foundation (RWJF) and the American Academy of Colleges of Nursing (AACN) (2008) detailed new national scholarship funding offering financial incentives for students with non-nursing undergraduate or graduate degrees to enroll in accelerated nursing programs at either the baccalaureate or master's entry level. The funding source considers this action valuable to combat the nursing shortage since it will not only provide more nurses in a shorter time span, but may ultimately address the nursing faculty shortage that has served to delay the expansion of nursing programs and increase the waitlists of potential students. A spokesperson for the two groups cited a study by the U.S. Health Resources and Service Administration that reported nursing students who enter the discipline at a baccalaureate level are four times more likely than diploma or associate degree entry nurses to pursue a graduate degree in nursing, with the potential to subsequently pursue a teaching role as this requires training at a graduate level.

There is scant current literature on the experience of nursing students' in accelerated programs taking up the practice of nursing, and there is no current literature on the experience of master's entry nursing students' taking up the practice of nursing. The evidence suggests that second degree students drawn to participate in accelerated programs experience their entry into and subsequent day to day clinical experiences of nursing practice differently than traditional baccalaureate entry students (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Kohn & Truglio-Londrigan, 2007; Meyer, Hoover, & Maposa, 2005; Miklancie & Davis, 2005; Vinal & Whitman, 1994; Walker et al., 2007). Their background of rich and varied lived experiences as well as their prior academic success can and should alter the methods used to enable them to take up the practice of nursing. However, their accumulated career, academic, and general life skills must be transformed and stretched to fit the new specific challenges and circumstances of being a nurse. Each of their everyday familiar and family skills are challenged by the context of health care settings and encounters with patient vulnerability and suffering. They must learn new skills and adapt old ones to meet and attend to the needs of a vulnerable stranger in high stakes situations and crises that students may have little exposure to or experience with prior to nursing school.

In encountering the nursing world, students' possibilities are framed by their particularly situated personal history, the practice of nursing with all of the ambiguities and uncertainties that are part of learning a practice, the current technological medical world, and the particular worlds of what matters to individual patients and families. The taking up of the practice of nursing occurs in this situated context and is rarely articulated because it most typically operates in a taken for granted and well-established background.

Knowledge gained through experience calls for new knowledge use as it broadens, extends, and refines existing knowledge and allows the fledgling practitioner to begin to recognize what is important in situations and compare situational similarities with prior experiences.

Research Question

What are the situated possibilities, activities, and engaged practical reasoning that are constitutive of and are constituted by the nursing student's world? A gap exists between our anecdotes and informal knowledge of these nursing students and the actual experiential journey to learn the knowledge, skills, and attitudes that form clinical competency, the experiences of the context of patient care, and how individual experience reflects on the shared cultural knowledge of nursing students. The overall goal of this interpretive research study is to articulate the background understanding of how students experientially take up the practice of nursing within the clinical setting. Specific aims include: What pivotal formative experiences do students identify as helping them develop and differentiate their clinical practice? What is ambiguous and what is clear to nursing students within the clinical situation and how does that change over time? How does "the press of the situation" (Benner, Tanner, & Chesla, 1996, p. 365) affect the student's performance? How do previous life experiences, education, and career choices influence the experience of second degree students and how does that change over time? What are the potential effects on learning of condensing and accelerating the curriculum as is requisite in second degree programs?

As students enter the clinical world and take up the practice of nursing there are shared background understandings for students that include skills, practices and

possibilities, how one encounters and uses objects and things as equipment, and how one relates to others. Through phenomenological study and interpretation the researcher can uncover and articulate the taken-for-granted and tacit meanings of skills and practices and their interconnectedness within the practice of nursing and the taking up of that practice. The researcher provides a holistic account of the person in the situation and strives to describe and interpret what gets disclosed and what might have gotten covered over (Heidegger, 1927/1962). In addition, phenomenological research into the lived experience of second degree students can build on the more prevalent studies of undergraduate students, and uncover more of the background understandings that ground the taking up of the practice of nursing while exploring the possible differences that may exist between students with different educational and experience levels.

CHAPTER TWO

REVIEW OF THE LITERATURE

According to the American Association of Colleges of Nursing (AACN) accelerated BSN programs are the fastest growing type of entry level nursing programs in the US (2005). Though not as prolific, as of a 2007 survey by AACN there were 56 masters's entry nursing programs nationwide and 13 more were in the planning stages (American Association of Colleges of Nursing, 2007). There has been little research on accelerated nursing programs in general, and only a fraction of these have focused on master's entry nursing programs. In addition, many of the survey research papers are over ten years old. This literature review explores the research on accelerated programs over the last fifteen years. I have included research on accelerated programs at the baccalaureate level that could perhaps illuminate aspects of master's entry programs, in large part because there are so few research studies on master's programs**.** Finally, selected studies of generic baccalaureate students are included since they reveal aspects of the students' taking up of the practice in a clinical setting.

The literature reviewed investigates the background of how student nurses learn to be nurses with a particular focus on second degree students taking up the practice of nursing in accelerated programs. The term "learn to be nurses" is deliberately global in order to encompass the actual performance of the nursing role after licensure as a nurse as well as the lived experience of students taking up the practice of nursing. The literature reviewed reflects particular understandings about how nurses *act* and how students *learn* to be nurses. As such it does not purport to represent all explanatory models of nursing knowledge. In addition, certain frameworks such as the information processing model

and heuristics are given only a brief summation in comparison with an embodied and situational model, in order to maintain a particular focus on the possibilities for different types of responses by the nurse or student nurse dependent on background understandings as well as current aspects of the situation. As will become evident in this review, the individual practitioner responds in a particular situation of inescapable uncertainty based on prior experiences and background cultural meanings. What seems to need a clearer articulation is how the nursing student takes up the practice of nursing within the ambiguous and uncertain world of the hospital clinical environment and culture.

The taking up of the practice of nursing occurs in a situated context that is rarely articulated because it most typically operates in a taken for granted and well-established background. Becoming a nurse is situated in the taking up of a practice. A practice relies on socially embedded practical knowledge (Dunne, 1997). There is no discrete set of content that stands alone and apart from the practice setting. In the integrative learning of a social practice notions of the good are taken up as well in the formation of an everyday ethical comportment (Benner, 1997). For the nursing student, world transforming identity changes as well as taking up practical skills and knowledge occur by engagement within the everyday world of a community of practice and in encountering and caring for patients and families.

The following section reviews literature on accelerated programs in nursing. Most of these studies focus on accelerated baccalaureate degree programs for students with undergraduate degrees in another field. However, there is a small body of literature specifically focused on master's entry into practice students.

Profiles of Students in accelerated programs

There have been no national studies comparing accelerated programs since the first survey research in 1992 (Wu & Connelly, 1992) and no survey information was found that targeted students enrolled in master's entry nursing programs. More recently Cangelosi and Whitt (2005) published a literature review of research on accelerated programs, however the researchers only cite articles on baccalaureate level nursing (BSN) programs, and only eight research studies were found. A summary of demographic data from a number of single site descriptive studies are included as well as data from the study by Wu and Connelly. An additional source is a report from AACN (2005) on second degree programs, compiling data from interviews with representatives from schools and health systems within their network.

The percentage of male students in second degree programs was more than twice as high as the percentage of male students in traditional programs (Meyer, Hoover, & Maposa, 2005; Seldomridge & DiBartolo, 2005; Wu & Connelly, 1992). Accelerated students are typically self-motivated (Meyer, Hoover, & Maposa, 2005; Miklancie & Davis, 2005; Vinal & Whitman, 1994; Walker et al., 2007), have a variety of life experiences (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Vinal & Whitman, 1994; Wu & Connelly, 1992), and fit the profile of adult learners (Cangelosi, 2007; Miklancie & Davis, 2005; Seldomridge & DiBartolo, 2005; Vinal & Whitman, 1994). These students hold higher expectations of the academic experience, are intolerant of busy work, challenge faculty, and expect current teaching practices (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Miklancie &

Davis, 2005; Vinal & Whitman, 1994; Walker et al., 2007). They are also eager to gain clinical experiences (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Miklancie & Davis, 2005; Vinal & Whitman, 1994). Student responses suggest that program pedagogies should acknowledge and incorporate the prior life and educational experiences of second degree students (Cangelosi, 2007; Shiber, 2003).

The main reasons given for choosing the program were the short length (Meyer, Hoover, & Maposa, 2005; Wu & Connelly, 1992), improved employment opportunities (Meyer, Hoover, & Maposa; Wu & Connolly) and the future salaries (Wu & Connolly). Students also cited the holistic nature of nursing and a lifelong interest in nursing as reasons for pursuing a nursing degree (Meyer, Hoover, & Maposa, 2005; Wu & Connelly, 1992). The personal financial difficulties of full time study (American Association of Colleges of Nursing, 2005; Meyer, Hoover, & Maposa, 2005; Wassem & Scheil, 1994; Wu & Connelly, 1992) and the stress due to the time limitations and workload of an accelerated curriculum (Meyer, Hoover, & Maposa) were the main barriers reported. In response to a question about their preparation for the accelerated program, students listed their prior experience in school (51.1%), motivation and maturity (20%), and time management skills (11.1%) as significant factors to meet the challenges of such a program (Wu & Connelly, 1992).

Comparisons of academic measures

Researchers have used a variety of measures to compare the academic performance of students in accelerated BSN programs with those students enrolled in traditional programs. Academic measures have included grades on coursework (Seldomridge & DiBartolo, 2005; Shiber, 2003), standardized testing performance

(Seldomridge & DiBartolo, 2005; Shiber, 2003), NCLEX pass rates (Bentley, 2006; Seldomridge & DiBartolo, 2005; Shiber, 2003), and attrition rates (Shiber, 2003). In one study there were no significant differences in course performance (Shiber, 2003), standardized test performance (Shiber, 2003), NCLEX pass rates (Shiber), and attrition rates (Shiber) between traditional BSN programs and accelerated BSN programs. In another study researchers found the second degree students outperformed the other group on course test averages (Seldomridge & DiBartolo, 2005), final GPA (Seldomridge & DiBartolo), and percentile score on the NLN test (Seldomridge & DiBartolo). The NCLEX-RN pass rate for second degree students were found to be slightly higher than the traditional group (Bentley, 2006; Seldomridge & DiBartolo, 2005), significantly higher (McDonald, 1995), or no different than the pass rate of traditional students (Shiber, 2003). One study noted that the second degree group scored higher on a measure of nursing performance (McDonald, 1995).

Literature specific to master's entry students

There is a dearth of literature focused on master's entry nursing programs; therefore I extended the time frame limitations of this review to include two single profiles of master's entry students from within the same program written two years apart and with a different focus and sample size (Smith, 1989; Smith & Shoffner, 1991). Each group compared demographic characteristics, job placements, acceptance within the health care community, and perceptions of level of preparedness between traditional master's nursing students with a background in nursing and those in a non-traditional group that entered the field of nursing within the master's program. Another article (Rich & Rodriguez, 2002) focused on master's entry students after graduation by surveying

health care providers' perceptions of this non-traditional group in their roles as nurse practitioners. One article is included that is non-research based, but rather is a descriptive account of a master's entry program tailored to meet the unique needs of this group of students. Finally, this review describes an article on the lived experience of accelerated master's entry graduates' transition to practice.

In the two studies profiling one school's programs (Smith, 1989; Smith & Shoffner, 1991), males in the non-traditional group significantly outnumbered males in the traditional group. Researchers found comparable academic success and self-perceptions of preparedness for clinical practice for traditional and non-traditional students. The researchers noted both groups felt a high level of acceptance from peers, supervisors, and physicians. Significantly 95% of the non-traditional group secured their first job in the direct clinical field (52% as staff nurse and 43% as nurse practitioners) while only 24% of the traditional group remained in the clinical field (7% staff nurse, 17% NPs, 20% management, and 41% educators) (Smith, 1989).

Rich and Rodriguez (2002) collected data through a demographic data questionnaire and an open-ended questionnaire to survey health care team participants' experiences, thoughts, and feelings about nurse practitioners in the non-traditional, master's entry into practice group. Respondents' themes reflected their perceptions that the complexity of the nurse practitioner role requires practical experience to gain a 'good nursing sense or intuition' especially when called on to make rapid assessments or decisions. In addition, the participants felt the non-traditional students lacked the system savvy to navigate the professional and institutional terrain of the health care system.

However, participants noted that practitioners with more experience can sometimes incorporate ritualized or outdated practices, and therefore these non-traditional group members would be less susceptible to this phenomenon. Comments also included that the master's entry students tended to be self-confident, highly motivated, and possessing more life experience. Significantly, most participants noted that over time the non-traditional NPs "catch up" with the NPs with an RN experiential background, though time frames were not given.

A descriptive clinical curricular model used by one school was designed specifically to fit the learning needs of students in an accelerated nursing program (Raines, 2006). The CAN-Care model is based in a partnership model and a constructivist approach to the clinical experience. Developers of the program acknowledged that the work and life experiences of second degree students potentially make their learning needs distinctly different from those of students in a traditional BSN program. Students are paired with one expert staff nurse from the beginning of the 12 month immersion program, remain at the same facility throughout the program, and work the same twelve hour shifts as their mentor/nurse. In this way staff nurses are in partnership with faculty rather than viewed as "outside" staff within the clinical learning site. Learning is focused on the patient's needs as interpreted through the nurse/student partnership and the hospital and unit culture. From the beginning courses the students are informed that the goals of the partnership between the college and health care institutions is "for the purpose of studying the practice of nursing and providing care to those in need of nursing" (p. 11). Thus, the program highlights the relational and situated aspects of nursing. Within this preceptor-supervised model, the clinical teaching is done primarily

by one nurse so that faculty "must relinquish control of the students" (p. 11) and instead serve as facilitators and evaluators. The faculty member is expected to nurture the learning and professional growth of the nurse expert (the staff person acting as preceptor) as well as the student. Though not specifically stated in the article, it would take a particularly skillful faculty member to provide this support. While the faculty member can provide a more theoretical perspective and evidence based practices, the nurse expert's practical reasoning skills need to be similarly acknowledged.

This situationally based approach is distinctly different from learning based on a list of context free objectives and tasks to be completed. The focus is clearly on the concrete experiences of the concerns for the particular patient within a particular clinical community of care. However some remnants of the rational/empirical paradigm remain. For example, students are responsible for providing weekly learning goals to their nurse expert. Such goals are helpful if they are understood as flexible and partial guidelines to be considered alongside the unpredictable situations of the practice. As part of the curriculum students "are asked to write stories on reflecting on their experience and its meaning in the context of their study and their emerging image of self as nurse" (p. 11). This activity reflects the constructivist underpinning of the model that relies on a cognitive notion of learning. While a reflective activity such as this is helpful it is important that the nurse expert, the student learner, and the faculty member understand that not all background practices and meanings can be discovered.

Cook, Becker, and Weitzel (1996) conducted research with a group of recent graduates of an entry level MSN program (N=13) to describe their experiences of integrating into the professional role as master's prepared nurses. The researchers

questioned how the new graduates transitioned to their careers with less clinical experience than traditional MSN graduates. Using a grounded theory methodology, the researchers identified the basic social psychological process was "Finding a place and forging an identity." In describing the process, the researchers noted that graduates begin the transition with an anxious sense of the limits of their experience compared with their advanced academic credentials, and that graduation itself does not transform the sense of identity for most graduates. It is possible that this transition to identity is similar to the transitional experience of new graduates from traditional programs.

Choosing strategies to manage self and others' expectations often included a decision to choose between the hospital environment and another setting. During the transition phase the graduates would often delay announcement of their "advanced" status and would pose as just another graduate nurse due to a concern that to do otherwise would be like "painting a target on my back." Part of the transition strategy was to seek out a manager with a positive view of master's entry into practice nursing in general.

These two studies by Rich and Rodriguez (2002) and Cook, Becker, and Weitzel (1996) provide some background understanding of issues that might affect masters' entry into practice students' lived experiences of taking up the practice of nursing following graduation from their programs of study. While not research based, the clinical curricular model by Raines (2006) offers an experientially rich learning community. However, there is no research available into the lived experience of master's entry nursing students during their course of study.

Lived experience of students in an accelerated BSN program

Two studies were found that described the students' experiences during their accelerated baccalaureate program. Cangelosi (2007) recruited nineteen former students from six different nursing programs in the mid-Atlantic region of the United States. The participants needed to have graduated from a second degree program within the last two years and to be currently employed in clinical nursing. The group was asked to reflect in advance on the question: "Is there an incident that stands out in your mind that best prepared you for your current clinical position?" The students were also asked during the interview to describe features of their accelerated program that they liked the most and the least, and to give a description of how their experience compared with that of someone in a traditional baccalaureate program.

Data analysis was described as using the human science research by van Manen. Both universal and unique features of each interview were identified. As stated, 'essential' meanings were uncovered and described in narrative summaries. The overarching pattern of "Clearing a Path Toward Possibilities" was identified in the common experiences and shared meanings of all participants. The students were confident in their academic abilities but felt more inadequate clinically. Faculty needed to be aware of this and "meet them where they are". Students desired more focused and individualized clinical teaching approaches that built on prior life experiences. Students suggested a reduction in procedural learning, busy work, and sacred cows; for example eliminating the demand that all skills needed to be done in a lab setting before they were done in the clinical setting. The accelerated students expressed a need for more clinical

experience and more effective clinical teaching approaches. This study opens up inquiry into the possible differences in learning needs of second degree students.

The lived experience of *being* second career baccalaureate students was interpreted in a study by Kohn and Truglio-Londrigan (2007). Using hermeneutic phenomenological methods the researchers interpreted interviews by five participants over the three semester course of their study. Three themes articulated their entry into the program: *Questioning one's place in the world, Seeing one's place in the world in another way*, and *Preparing for the plunge*. Two other themes, *Trying transitions* and *A bundle of emotions*, described their transitions from their former lives into an intense and stressful place of feeling novice again. The themes of *Student imbalance* and *Faculty control* described the student' sense of a lack of faculty support and students' desire for more input into curriculum changes that affected their experience. Though this is a single study with a small sample size it proposes some interesting lines of inquiry about the situated transitions and emotions of the students as they prepared and then took up the practice of nursing.

In summary, the literature reviewed on accelerated programs gives some understanding of the demographic differences in second degree student group. These students tend to be highly motivated, perform at least as well as traditional students on academic measures, and have higher expectations of their academic experience. They acknowledge the limits of their experience and therefore feel a strong need for more clinical hours as well as more meaningful clinical experiences during their education. Their background of rich and varied lived experiences as well as their prior academic success can and should alter the methods used to enable them to take up the practice of

nursing. However, there is no current research on the experience of master's entry students taking up the practice of nursing while engaged in their clinical nursing education.

Benner's study of skills acquisition in nursing

Benner's *From Novice to Expert* is the seminal work on the acquisition of practical knowledge while taking up and within the practice of nursing. Using interviews with beginning and expert nurses paired as new graduates and their preceptors (21 pairs from 3 hospitals), the researcher aimed to articulate the differences in the perceived clinical picture between the pairs. The participants were asked about patient care situations they had in common that stood out for them. They were also asked what clinical knowledge was particularly difficult to learn. Separate interviews and/or observations were conducted with 51 additional experienced nurses, 11 additional new graduates, and 5 senior nursing students.

The resulting theory of skill acquisition in nursing (Benner, 1984) draws on the work of Dreyfus and Dreyfus ((1980) and posits that nurses gain skills by moving through transitional roles from novice to advanced beginner to competent to proficient, and finally, to expert. Furthermore, clinical experience is necessary for the individual to move through the various stages of expertise in nursing, beginning with a narrow, rule-based clinical view. The Dreyfus Model of Skill Acquisition (original research was to study the response of pilots in emergency situations) proposes that reasoning and skilled know-how changes with experience as an essential part of learning any complex practice such as nursing (or any science-using practice).

Benner states that expert nurses use a certain "discretionary judgment" in the clinical setting that is a departure from rule based practice, and that expert clinical judgments are context-based. Benner views undergraduate nursing students as novices and states most new nurse graduates are "advanced beginners", defined as "ones who can demonstrate marginally acceptable performance, ones who have coped with enough real situations to note (or to have had pointed out to them by a mentor) the recurring meaningful situational components that are termed *aspects of the situation* in the Dreyfus Model" (Benner, 1984, p. 291). It should be noted that according to Benner, the experiential transitions are not solely due to the passage of time, but a turning around or added nuance to one's expectations of preconceived notions in particular situations.

In *Novice to Expert* (1984), Benner conceptualized seven domains of nursing based on interviews with expert nurses: 1) the helping role; 2) the teaching-coaching function; 3) the diagnostic and patient monitoring function; 4) effective management of rapidly changing situations; 5) administering and monitoring therapeutic interventions and regimens; 6) monitoring and ensuring the quality of health care practice; and 7) organizational and work role competencies. Each domain is broken down into what might be called existential skill sets since most are based on the particular context over time. In addition, Benner cautions that these domains were conceptualized through narratives and necessarily cannot make explicit all aspects of nursing knowledge that might be evident within the myriad concrete situations that nurses find themselves in, as students or as new staff nurses. Emotional engagement with the patient, the skill of involvement is a thread that can be noticed throughout these domains. As noted by Benner, et al., there is both a "good" or better kind and a "good" or better level of involvement with the patient that is

learned through experience as well as "developing the skill of staying open to a clinical situation, without being overwhelmed or closing down prematurely" (1996, p. 309).

While Benner's work provides background understanding of the transitions in nursing practical knowledge gained through experience, the focus attends to all stages of skill acquisition and in my study I proposed to highlight the novice stage and to more clearly articulate the critical tasks, skills of involvement, and developmental tasks associated with this crucial novice stage of skill acquisition of master's entry students. The Benner and Dreyfus studies created an opening into an alternative model of how individuals take up the practice of nursing.

Studies of generic nursing students' clinical experiences

Decision-making

Nursing students' decision-making during their first clinical rotation was the subject of a qualitative case study by Baxter and Rideout (2006). Specifically, the researchers aimed to uncover how the students (n=12) determined a need for decision-making in a situation, how the students responded within the framework of a decision, the types of decisions that were made, and the inhibiting or enhancing factors in a decision. The students were given written instructions to write journal entries about a situation, positive or negative during the clinical day where the student needed to make a decision. Steps of a reflective practice were described, and included as part of the instruction to "analyze and describe" thought and feelings as well as a description of one's actions. The students were then asked to consider what could have been done better. Journal entries were done twice over the first two weeks of the clinical course and served as the basis for discussion during unstructured interviews. The two clinical faculty were interviewed as

well. Though not specified within the account, the framing of the research question in decision making and the instructions given to the students as to how to write their journal entries, sets up the analysis to follow a rational-empirical tradition.

Three key encounters formed the basis of student's decision-making: encounters with patients, nursing staff, and clinical faculty. Each encounter was further described as including an emotion-based and a knowledge-based response. For example, the student-patient encounter was described as the source of many conflicting emotions with a lack of confidence and fear being the emotions most often encountered. Students described the fear of making a mistake, the fear of communicating with the patient, and the fear of hurting the patient by making a mistake.

The researcher's account seemed limited by the decision to write descriptions from within themes. However, although the directions to the student were to analyze and describe thoughts and feelings, the students described these contextual features within their situated accounts since the situation is what gives meaning to their thoughts and feelings.

Another research article describes this inadvertent tendency for students to describe whole situations (Garrett, 2005). Garrett performed a phenomenological study of final year nursing students' development of knowledge, skills, and attitudes associated with clinical decision-making. The author's intent was to have the students create a consensus concept map of clinical decision-making as part of triangulating data. Twenty one students also completed a researcher-devised individual self-assessment questionnaire that included open-ended questions about the students' knowledge of clinical decision-making as well as closed questions about their level of confidence and

skill in decision making. It was unclear why the researcher chose to use a survey method with such a small sample. Twelve students were selected to participate in a focus group to further explore the students' experience of clinical decision-making. Since the researcher's stated purpose was to understand the phenomenon of clinical decision-making in final year nursing students through their lived experiences it would seem contradictory to present data in a consensual model.

Consistent themes were that students associated their level of knowledge and experience with their perceived skill in decision-making, and a lack of self confidence in their ability to make decisions was a ubiquitously shared finding. Garrett suggested that the majority of students conceptualized clinical reasoning in absolute terms "by applying 'templates' based upon prior experience" (p. 38), although there were no examples of students' statements given to explicate this for the reader. This is a weakness in the study since the reader is unable to participate in consensus of the findings by agreement or disagreement. In conclusion the researcher stated, "although the students demonstrated a complex theoretical conceptualization of clinical decision-making, they tended to focus on the impact of clinical decision-making, and the value of concrete experience rather than the value of cognitive skills in the process and application of decision-making theory to practice" (p. 30). Garrett considered the students' focus on concrete experiences rather than a description of the application of cognitive skills, as an undesirable situation in nursing clinical education.

Cognitivist models. Cognitivist models such as decision theory posit that decision making involves choices made under conditions of uncertainty. Essentially mathematical, the premise is that decision rules can be weighted by the probability of particular

occurrences. Thus an action is chosen based on the highest probability of achieving the most highly valued outcome. Heuristics refers to short cuts or rules of thumb used as decision rules with problem solving guidance embedded in them. Thus pattern recognition is often the background strategy used to match the current situation with past experiences (Cioffi, 1997).

Another cognitivist model, information processing, describes problem solving in terms of the one to one relationship between the problem solver and the problem. Information processing theory assumes that there is a limit to our ability as humans to think rationally. To compensate for these limitations, human thinkers selectively collect and process data determining its relevancy through a hypothetico-deductive method (O'Neil, Dhuly, & Chin, 2005). Cognitive strategies are devised based on task complexity and experience (Tanner, 2006). All cognitivist models are based on a representational view of the mind that posits that thinking and perceiving are mediated by cognitive representations to translate incoming data.

The models 'end points' (hypothesis generation, hypothesis-driven assessment, hypothesis selection, and nursing action) resemble the steps of the nursing process, frozen in time like snapshots, and therefore unable to account for the transitions over time that are more realistic of patient care situations (a form of practical reasoning or phronesis) (Taylor, 1993). Decision theory models are problematic in their assumption that the clinician makes all "rational" choices from a detached and disengaged position outside of the situation based on a mental representation of "if/then" statements. In addition, while decision support systems might be effective in certain situations they cannot replace the sense of salience gained by the embodied and engaged knower. In practice, the nurse or

nursing student, is confronted with unstructured problems with multiple possibilities as exemplified in this unlikely but apt comparison by Dreyfus and Dreyfus (1986):

> A boxer seems to recognize the moment to attack, not by combining by rule various facts about his body's position and that of his opponent, but when the whole visual scene in front of him and sensations within him trigger the memory of early similar situation in which an attack was successful. We call this intuitive ability to use pattern without decomposing them into component features 'holistic similarity recognition'. (p. 28)

Situated models. Brooks and Thomas (1997) performed a descriptive exploratory study to elicit students' processes of making decisions in clinical situations. Noting that the teaching of decision making in nursing education is typically framed in the nursing process and other cognitive models, the researchers aimed to shift to a more holistic view of decision making. The study also aimed to "validate Brook's theory of intrapersonal perceptual awareness, a middle range theory derived from King's interacting systems framework and to extend King's work by making perception (sensory and intuitive), judgment (cognitive and affective), and decision making explicit concepts in the personal system" (p. 50). Eighteen senior baccalaureate nursing students in three programs in one geographic area were asked to read a clinical vignette and were then interviewed about their decisions regarding the clinical situation. The emergent theme was personal knowing; everything filtered through the individual's unique self. The researchers concluded that perception, judgment, and action interact within the individual and cannot be separated or observed. In fact, contrary to the researchers' initial intention to explicate perception, judgment, and decision making as discrete concepts, "they occurred interactively, in a nonlinear manner, in which all or most of the intrapersonal characteristics were identified, regardless of the particular question" (p. 56)

Although this model accounts for the 'fusion' of experience in perception, judgment, and action within a social network the student is viewed as a private subject, the unique self. The model focuses on differences rather than attempting to uncover the students' shared meanings within their taking up of the practice. The model ignores the social embeddedness and shared quality of all knowledge. While each person is situated in their personal historical background, shared cultural understandings form the background of how and why decisions are made. Brooks and Thomas' theoretical model is comparable to the information processing and decision theory models in that all reflect a rational-empiricist tradition that assumes that the individual is an isolable independent being with absolute properties and abstractable traits that separates the knower from the known.

The account by Brooks and Thomas approached the project holistically but got caught up in the rational-empiricist tradition. Alternatively, The Embodied Practitioner clinical model of Benner, Tanner, and Chesla (1996), based on research using narrative interviews and observations of expert nurses considers an embodied and situated articulation of clinical judgment within a practice that is a departure from the more narrow confines of the cognitive models of decision making. The model does not suggest the supplantation of analytic cognitive models of clinical decision making. Rather it proposes that technical rational models of decision making do not capture all that is contained in the clinical judgment of nurses. Their model includes the following conceptions: the nurse's notion of the 'good', practical wisdom, engagement, knowing the patient, and intuition. These researchers propose that schematics that list a progression of choices can't account for all the subsets of possibilities that compose the

"fuzzy" sets of the clinician's perceptions of a clinical practice environment. Narrow technical rational models do not account for the individual characteristics of the clinician: what emotions, perceptions, and meanings the nurse brings to the clinical arena and are, in fact, necessary to exercise good clinical judgment. They also don't account for the manner in which emotions as well as cognitions are co-constituted within a social/cultural/historical realm nor do they account for the clinician's way of framing the situation, timing within the situation, or transitions over time (Benner, Tanner, & Chesla, 1996).

Benner, Tanner, and Chesla (1996) describe the notion of the good (MacIntyre, 1984) as embedded in practice and used in everyday ethical comportment in which the nurse engages each time she or he encounters a patient. It is based on the usual code of ethics yet is more inclusive than a rights or procedural notion because it considers the good behind the right. Each decision that is made based upon the clinician's notion of the 'good' in the particular situation that leads to the decision for the patient. It requires a particular contextual situation since it is based on 'noticing and attending' what is important to the patient and family (Benner, Tanner, & Chesla, 1996). Thus, the ends are co-constructed with patient and family.

Practical wisdom refers to the accumulated judgment gained from prior clinical experiences. It has been described as tacit knowledge (Polanyi, 1958), skilled know-how (Benner, 1984), or knowing-in-action (Schon, 1983). Practical wisdom requires concrete experiences to form a deep background understanding (Benner & Tanner, 1987; H. L. Dreyfus & Dreyfus, 1986). The accompanying theory chapter provides a fuller description of practice as well as the community of nursing sharing the practices.

Involvement in the situation is the manner in which the nurse engages with the patient. In a subject/object relationality the clinician stands outside the situation "touching reality only through mental representations" (Benner, Tanner, & Chesla, 1996, p. 8). Contrary to this objective 'clinical stance', the involved nurse stands within the context of the situation rather than obtaining a private, outsider's view.

Nurse researchers have provided definition and documentation to the term *knowing the patient* (Benner & Tanner, 1987; Bevis, 1988; Jenks, 1993; Tanner, Benner, Chesla, & Gordon, 1993). Tanner et al. described *knowing the patient* as specific to a particular patient in a particular care environment. This description also included involvement with the patient, a sense of the patient's vulnerability and the need to preserve dignity, and a general advocacy on behalf of the patient in response to those factors.

Intuition is a direct way of knowing based on the nurse's world of everyday clinical meanings that are not readily apparent or describable but are experience based. Such nonconscious holistic discrimination without resorting to rational calculation is one of the hallmarks of expert practice (Benner, Tanner, & Chesla, 1996; H. L. Dreyfus & Dreyfus, 1986). Rew (1988) defined intuition as knowledge that is received in an immediate way, perceived as a whole, and not arrived at through a conscious analytic process. Six key elements of intuition according to Dreyfus and Dreyfus include: 1) pattern recognition, 2) similarity recognition, 3) common sense understanding, 4) skilled know how, 5) sense of salience, and 6) deliberative rationality. Therefore, intuition can be seen as non-deliberative and based on prior experience (H. L. Dreyfus & Dreyfus, 1986).

Beginning clinical experiences

Various research studies have been conducted focusing on the beginning clinical experiences of nursing students. Sedlak's aim (1997) was to qualitatively describe both the reflections and critical thinking processes of baccalaureate nursing students during their first clinical practicum (n=7) using a case study approach. The researcher's definition of critical thinking cited the relationship between critical thinking and reflection: "a reasoning process in which the nursing student reflects on the ideas, actions, and decisions of oneself and others related to clinical experiences" (p. 12). Sources of data included weekly reflective journals (over the twelve week course), three structured interviews with each participant, and observations of students within the lab. The instructions for writing in the journal were to write about a clinical experience that they perceived as important that required some type of decision. In the interviews students were asked to tell about decisions they've made within the clinical setting since the beginning of the semester. It was not stated if there was a different format for each of the three interviews.

The data was then used to establish themes by initially categorizing information into a reflective domain and categories and a category of critical thinking dimensions, based on the results of a pilot study. The major themes identified were the development of a professional self perspective with orchestration of the emotional self, the development of a perfectionist perspective, the development of a caring perspective, and the development of a self directed learning perspective. It was unclear how the researcher envisioned the relationship between critical thinking and the thematic analysis.

The researchers' account is limited in a comparable way to the study by Baxter and Rideout by decontextualizing situational features and then describing the features outside of the context, although Sedlak did produce "portraits" of students that were described as narrative accounts of their lived experience through a focus of clinical reflections and critical thinking. The brief descriptions of the student's accounts seemed to give a much broader and richer contextual meaning than was represented within the theme. In addition descriptive remarks within a theme revealed a wider range of perspectives than the thematic name. For example, the theme of perfectionist perspective was initially described as the students' need to be perfect. Yet the accounts by students include a fear of "doing something wrong", "having something happen and having to fix it", sensing their deficits in organization, communication, and assessment, and feeling the time pressure of having to make decisions with a very limited background understanding. Excerpted text from students' accounts vividly described the students' concerns within unanticipated and uncertain situations and little if any background skills to guide their doing. An alternative view than that presented is that the students were guided less by a desire to be perfect then by their beginning sense of what is at stake in caring for the sick and vulnerable. As noted by Benner et al. in description of the abstracted mental representations of a cognitivist view:

> This view overlooks the possibility that humans inhabit their worlds in an involved way, rather than through mental representations or schema; salient aspects, nuances, and meanings simply show up. The cognitivist view also fails to recognize the ways in which clinicians become socialized into their professional culture, developing habitual ways of seeing and responding to patients. (p.9)

Critical thinking has emerged as a central concept within nursing for at least the last twenty years (Cody, 2002). A literature search of in Medline limited to the last fifteen

years yielded 1295 articles on critical thinking and nursing and 610 articles on critical thinking and nursing education. As noted in the definition of critical thinking by Sedlak, the term is often used to conflate all that is 'best' in nursing practice. In the clinical setting, clinical reasoning utilizes a number of techniques, dependent on clinical context, experience, and time available. In routine decisions, critical thinking is not required (Adams, 1999; Benner, 1984; Benner, Hooper-Kyriakidis, & Stannard, 1999). In situations requiring rapid action the nurse often does not have the luxury to critically reflect on what to do next. The essential project of critical reflection or thinking is to deconstruct the taken for granted and/or the accepted or received view. Thus, properly conceptualized, critical thinking is a valuable part of nursing education and practice. However, "by holding up critical thinking as a large umbrella for different models of thinking, students can easily misconstrue the logic and purposes of different modes of thinking" (Benner & Sutphen, In publication, p. 6).

Beck (1993) performed a phenomenological study of student nurses' written descriptions of their first clinical experience (n=18). Beck's aim was to access "the essential structure" of the phenomenon as experienced rather than as a reflection of what the person perceived. Therefore, the students were presented with the following prompt: "Describe an experience you had during your first day of clinical as a nursing student. Please share all the thoughts, perceptions, and feelings you can recall until you have no more to say about the experience." Implicit in this prompt is Beck's theoretical assumption that leaving out the filter of reflection would allow the uncovering of more of the phenomenon as experienced**.** However, while such a description asks for an

exhaustive recounting of the event it is this reviewer's impression that a dialogical interview or multiple interviews would uncover more of the background of the event.

Using Colaizzi's phenomenological method Beck described the following themes: Pervading anxiety, Feeling abandoned, Encountering reality shock, Envisioning self as incompetent, Doubting choices, and Uplifting consequences. Given the overall negative tone of the student encounters it is striking that at the end of the day they felt their caring had made a difference.

Neill (Neill et al., 1998) utilized graduate students in a nursing research seminar to assist in a study of sophomore nursing students during their first clinical practicum. Using an exploratory phenomenological method as developed by Benner and colleagues, the researchers gathered data through focus groups, individual interviews, and observations (n=75). Initially the students were observed during their time in the hospital clinical practicum. Thematic inquiry in the focus groups was based on these observations. Finally, a subset of students was interviewed on a one-to-one basis for 20 to 45 minutes, focusing on topics raised in the focus groups. The graduate students followed a scripted series of questions for the focus groups but the authors did not state the guide used for the interviews that were also conducted by the graduate students.

During data analysis, the three initial lines of inquiry developed were: teaching and learning experiences, student feelings, and interpersonal interactions. Themes identified included: 1) What am I doing here, 2) How do I learn here, 3) Who are the mentors, 4) Where can I connect, and 5) Did I do well. While not specifically mentioned by the researchers, combining all of these themes presents a fairly broad articulation of the students' practical reasoning within a new environment. The issues included in the

first theme mirror findings in both the studies by Sedlak and Beck regarding the personal impact of taking up the practice of caring for the sick. However, Neill et al interpreted the student's account of "What am I doing here" as role confusion.

A descriptive phenomenological study such as the research by Beck or Neill et al does not account for variations within the students' responses and instead strives for one essential description. In addition, descriptive phenomenology requires the researcher to bracket out her own background understandings. An interpretive phenomenologist would suggest that the researchers' initial question as well as analysis of findings are require the presence of a researcher's point of view or bias for anything to show up at all**.**

Final clinical experiences

White (2003) performed an interpretive investigation into the clinical decision-making of nursing students in their final semester of study (n=17). The researcher specifically noted the need to gain a holistic picture of the clinical situation as well as the background meanings and understandings of the student in order to uncover a clearer understanding of students' clinical decision-making. Using Heideggarian phenomenology and hermeneutical analysis, White posed the research question: What essential experiences are associated with learning clinical decision-making among senior nursing students?"

Students were interviewed by the researcher for a period of 60-75 minutes, using an interview guide. Data were analyzed utilizing a modified seven-step approach developed by Diekelmann and Allen. Five essential features of decision-making were identified: 1) Gaining confidence in skills, 2) Building relationships with staff, 3)

Connecting with the patients, 4) Gaining comfort in self as a nurse, and 5) Understanding the clinical picture.

Students stated that gaining confidence in both technical and communication skills allowed them to focus more on the patient. A lack of confidence in skills would cause the student to become preoccupied with their own performance and the possibility of making an error. Obviously more confidence thus allows the student to be more open to connecting with the patient as well as understanding the big picture and the other identified essential features.

Students noted that their relationship with staff was critical to making decisions. Support, encouragement, trust, and commitment on the part of the nurses were all mentioned as adding to the students' confidence and reciprocally in their ability to learn and make decisions. Nurses that shared their thought processes with students were considered particularly effective as clinical teachers.

Connecting with the patient meant being open to understand what mattered to the patient. Care was individualized to meet the concerns of the patient. The researcher's interpretive comments also included an acknowledgement by the students of the patient's life as connecting a past, present, and future.

What is evident in this account and missing in others is a focus on the situation and what matters in the situation. According to Hubert Dreyfus (1999), the three interrelated and foundational aspects of human intelligent behavior are: "the role of the body in organizing and unifying our experience of objects, the role of the situation in providing a background against which human behavior can be orderly without being rule-like, and finally the role of human purposes and needs in organizing the situation so that

objects are recognized as relevant and accessible" (p.234). Everything that an individual does is based on a self interpretation of being in the world that is never fully objective and always involved (H. L. Dreyfus, 1994).

Student accounts focused on the concrete situations of patient care. The interconnectedness of the five themes was evident and based on the student's level of knowledge. A significant aspect was the students' reliance on staff for support with minimal involvement of the instructor. White interpreted this as mimicking the situation the students would soon be in as nurse graduates. Furthermore, she suggests that students' clinical decision-making might be enhanced by remaining in one consistent environment in which the students can spend more time developing trusting relationships with staff and getting to know patients and spend less time getting to know a "new" unit.

Cooper, Taft, and Thelan (1996) conducted research utilizing what was described as a qualitative design using naturalistic inquiry to gain a better understanding of what students were thinking and feeling during their final clinical experience. Participants were part of a convenience sample of students in a clinical group that utilized asynchronous online conferencing for their clinical post conferences. The researchers noted the value of narrative reflection as an educational tool and required students to post a weekly reflection "to describe a clinical situation or incident and then write about what they were thinking and feeling at the time." Though the number of participants was not specifically stated, the researchers noted that students posted five or six reflections during the semester and a total of 168 narrative reflections were received and included in the study over two semesters.

Content analysis of the narrative reflections uncovered seven themes including: Being aware of human vulnerability, Feeling the weight of responsibility, Recognizing limits, Evaluating self, Seeing the patient and family perspective, Confronting ethical issues, and Facing reality versus expectations. Themes were further explicated by a chart of associated subthemes, as well as examples of students' narratives. For example, the theme of "Recognizing limits" included associated themes of the limits to possibilities within the particular clinical situation, such as: Patient resistance to care, Patient psychosocial behaviors, Family psychosocial behaviors, Time constraints, and Communication barriers.

Unlike the research by White, this research is limited by the lack of integration of themes. Presenting the themes within concrete situations that reflect the context would present a stronger case. In addition, the themes might have been further articulated if the data were collected in a more dialogical manner. Finally, the initial prompt categorizes the student response as cognitive or emotional whereas in the concrete situation these would be difficult to separate, and in fact cannot be discerned as distinct in reading the excerpts from the students' accounts.

Reflection and clinical nursing education

Reflection and reflection on practice have become integral aspects in nursing education programs (Clarke, James, & Kelly, 1996; Ruth-Sahd, 2003). A literature search of the PubMed site using the terms 'reflection' and 'nursing education' noted 438 articles written in the last ten years. As the specific focus of this review is to provide background understandings of the nursing student's embryonic journey towards the practice of nursing (learning to become a nurse), the discussion of reflection on practice

will be brief and focused on a small set of the burgeoning literature. This author wishes to note that there are excellent reviews on reflection including (Clarke, James, & Kelly, 1996; Ruth-Sahd, 2003). Terms on reflection in practice such as deliberative rationality (H. L. Dreyfus & Dreyfus, 1986), thinking in action (Benner, Hooper-Kyriakidis, & Stannard, 1999), or reflection-in-action (Schon, 1983) will not be included in the current discussion of reflection because they all call for a qualitatively distinct approach to situated thinking rather than post-hoc reflection. Rather, this review focuses on thinking after an event.

Ruth-Sahd (2003) refers to reflective practice as a means of self examination that involves looking back over what has happened in practice in an effort to improve or encourage professional growth. Reflection on practice is often triggered by a particular event (Boud & Walker, 1998) or breakdown in practice (Benner & Wrubel, 1989). In a review of the literature on reflection Atkins and Murphy (1993) cited three main stages in deliberative reflection: 1) an sense of discomforting feelings or thoughts, 2) a critical analysis of those feelings, and 3) culmination in the uncovering of a new perspective.

Typically the nurse or student reflects with a focus on personal actions within the situation. Something about the situation is disturbing and the individual reflects on his or her actions:

> Through reconsideration and discussion of concrete whole experiences, we reach new understandings of the meaning of the experience. We may uncover taken-for-granted assumptions about the meaning of particular practices, or habitual ways of being. Such reflection heightens our sensitivity and capacity for appropriate responses in subsequent experiences. Reflection in the sense we mean it here is not objective, detached, standing away from the situation. The particular experience is separated by time, not necessarily by engagement. (Benner, Tanner, & Chesla, 1996, p. 325)

Stockhausen (2005) undertook a qualitative study using the reflective instruments of unstructured debriefing sessions and journal writing in order to "expose the significant events undergraduate students reflect on during clinical experiences as they learn to become nurses" (p.16) (n=40). The researcher also hoped to gain new insight into the taken for granted experiences of the nursing students during their clinical practice. Thirteen debriefing sessions were audiotaped and unstructured journals were collected from each of the students at the end of the ten week clinical placement.

Although a particular methodology is not identified, content analysis revealed a main category, "Learning to become a nurse", with supporting themes of entering the world of the patient, clinicians (RNs) making a difference, and constructing an identity as a nurse. Within the theme of constructing an identity as a nurse were the sub-themes of developing confidence, confirmation, and assimilating theoretical and clinical knowledge. Students were invited to review the results of the analysis to ascertain if they felt it was an accurate depiction of their accounts. The students positively acknowledged the results, and the researcher suggested this further reflection could also encourage individual insights into practice.

Entering the world of the patient included what the researcher termed "a reciprocity of one another's presence and a united understanding of the event" (p.10). Stockhausen stated that through patient interactions the students learned "the humility of caring" and "being with" the patient. Students noted that their learning takes place alongside a nurse and that nurses made a difference in their experiences in both positive and negative ways. Specifically, students portrayed the positive nurse mentor as one who

is approachable, friendly, shares tricks of the trade, acknowledges their status as 'learners', and explained their clinical decisions and rationale.

Within the researcher's framing, constructing both a personal and professional identity as a nurse followed an iterative cycle of confidence and competence through experiences. The psychomotor skills are what are clearly visible and thus are clear measures for the students to gauge their competence through time in undertaking what a nurse does. However, proficiency and competence in the doing of skills freed the student to then focus on the patient. As one student stated in describing this new ready-to-hand skill:

> I didn't have to think about everything I was doing. Now when I do aseptic technique I can talk to the patient as well as do the dressing. The first couple of times doing it, you can't think of anything else but the wound because you're concentrating on your sterile field and technique. Before I sometimes forgot there was a patient there. (p. 12)

The students were also able to integrate theoretical concepts into the meaningful context of concrete situations. In addition, making comparisons and distinctions while gaining a repertoire of situation-specific knowledge helped construct, or form (from an interpretive phenomenological perspective) identity. Stockhausen's interpretation reflects a social constructivist framing that is at odds with the constitutive stance taken within the interpretive phenomenological project that is the focus of this review of literature.

Pulled up short

An alternative or additional view of the knowledge gained from experience is based on work by Gadamer and then Kerdeman. Gadamer (1975/2004) described experience as the turning around of expectations that occur within our absorbed and involved practical existence. As noted by Gadamer, "experience is initially always

experience of negation; something is not what we supposed it to be" (p. 349). Building on Gadamer's work, Kerdeman (2004) describes the experience of being 'pulled up short' as a type of non-reflective learning. Lived understanding is pre-reflective and therefore, in itself not subject to control or regulation. "We assume that challenging our prejudgments is a choice we govern or an activity we can monitor and direct" (Kerdeman, 2004, p. 145). Within our absorbed, engaged practical stance we forget there are limits to what is possible. However, when our beliefs are thrown into doubt, we are pulled up short and begin to question our presuppositions based on the disruption that has occurred within our smooth flow. A degree of tension is caused by the world not fitting into our expectations or sense of the possibilities. This is in opposition to the notion of 'regulating' one's thinking as in cognitive accounts.

Though Kerdeman's work focuses more on larger transformations in self understandings, being pulled up short equally applies to everyday experiential learning. Being open to the experience of being pulled up short provides access to an interpretation of the turning around of student assumptions over time and through transitions in the situation.

Confidence and clinical reasoning

Haffer and Raingruber (1998) used a narrative approach to discover students' experience of developing clinical reasoning skills while enrolled in a clinical reasoning course. Data collection of students' reasoning and reactions to the reasoning of others were collected through videotapes of the class as well as reflective logs. The class was comprised of 15 students, most enrolled within the last two semesters of the five semester baccalaureate nursing program. However, one student was in the third semester and two

were in the second semester. Though not explicated it seems likely that the students with more clinical experience would give different accounts of their clinical reasoning. Both students and experienced nurses presented scenarios during the class and were instructed to use as much detail as possible and to allow the story to unfold as it occurred over time. The instructors encouraged dialog to uncover the reasoning behaviors within the scenarios. Within the final thirty minutes of class the students wrote reflective accounts of 'standout' scenarios, specifically in terms of reasoning processes.

This particular article focused on confidence as an aspect of critical thinking and clinical reasoning. The research used an interpretive phenomenological perspective; the researchers proposed that critical thinking and reasoning are affective as well as cognitive, and are grounded in practice so that a narrative approach was chosen to access holistic accounts of the students' interpretations of practice. The researchers identified narrative themes, exemplars, and paradigm cases from the logs and the videos. From their initial position of apprehension, self doubts, and decreased confidence, students displayed a shifting from confidence-diminishing accounts to confidence-enhancing experiences and understandings. The shifting areas included: 1) Overwhelmed by experience to drawing strength from other's experiences; 2) Perceiving others as more competent to learning that capabilities are comparable, 3) Lacking the confidence to question to uncovering the power of questioning; 4) Focusing excessively on the possibility to do harm to looking towards positive action; 5) Feeling total responsibility to experiencing comfort in shared responsibility; and 6) Being disorganized and scattered to finding ways to focus under stress. Haffer and Raingruber acknowledged the interrelatedness of these six aspects of confidence and the reciprocal link between experience and confidence. In

addition, they cited work by Benjamin that described how self understanding and confidence allow one to feel more at home in the practice setting. Referring to Heidegger, the researchers noted that confidence and self-understanding emerge out of situations and relationships one is involved in and gives one a sense of who they are (Heidegger, 1927/1962). Recognition within the relational world of nursing through the response of others is constitutional of the individual student's identity as a nurse.

Students enacting caring

A student can only learn what is salient in a situation by involvement in the situation (Benner & Wrubel, 1989). It is from a place of concern that one perceives what is at stake, relying on background cultural understandings of what matters. According to Benner (1997), care ethics are embedded within the social community of nursing practice. Care ethics are situated, based on communal notions of the good that are only perceived and realized in particular situations that are attentive to the needs, desires, and possibilities of the parties involved, in particular the patient and family members. The following articles focus on students' understanding of the concept of caring while engaged in clinical practice settings.

Sadler (2003) conducted a pilot study to measure the caring efficacy of baccalaureate nursing students cross-sectionally for all four grades, pre-nursing through final semester seniors (n=193). The students' self-reported caring competency was measured using the Coates Caring Efficacy Scale (CES). Scores were consistent within class groups and showed no statistical difference in scores between classes. Final semester seniors identified family members as having the greatest impact on their development of caring and only a few students singled out the influence of the nursing

curriculum. The findings of this research reveal the always already meaning of caring that exists for the individual having grown up within a culture. While the students' experiences caring for the sick and vulnerable can extend this meaning, their lived experiences within a family and larger culture undoubtedly provide the larger background understanding of what it means to care.

Kosowski (1995) enacted a critical phenomenological study from a feminist perspective "to discover, describe, and analyze how nursing students learn professional nurse caring" (p. 235) during clinical practica. The researcher purposively selected junior and senior baccalaureate students (n=18) and conducted in depth unstructured interviews framed with the question, "Describe a clinical situation in which you learned professional nurse caring." Data was analyzed using a modified Colaizzi approach.

An interesting and unanticipated result of data analysis was the researcher's discovery that in order to describe how they learned caring the students had to describe their enactment of caring. Thus the central theme was the inextricable relationship between caring and interacting with patient in embodied caring knowledge. The main theme was characterized by the sub themes of Creative Caring and Learning Caring. Creative caring included connecting, sharing, being holistic, touching, advocating, being competent, and feeling good. Learning Caring included role modeling, reversing (lessons learned from caring practice breakdown), imagining, sensing, and constructing.

Other researchers have also explored the experiences of students' caring in interactions with patients. Beck (1997) studied the lived experience of students caring for dying patients. Themes included experiencing a wide range of emotions, contemplating patient's life and death, supporting their family, feeling helpless as an advocate,

providing holistic care, and learning through care of the dying. Elfried (2003) described the lived experience of students being with someone who is suffering. The essence of the experience was "bearing witness to suffering" and included sub themes of struggling with the unexplainable, being with the patients, and seeing possibilities in the midst of suffering.

An interesting contrast is noted in a study done in Israel (Orland-Barak & Wilhelem, 2005) of student nurses within a clinical practice setting described by the authors as emphasizing performance in an apprenticeship model. The researchers compared this model with other programs that followed a more constructivist-humanist pedagogy, although the latter was not further articulated within the article. The apprenticeship model was described as one involving role modeling activities of teachers within the school followed by the students' performance of skills in a standard evaluation format.

The research question was broadly conceived: "What characterizes student nurses' perspectives towards learning to become a nurse in the clinical practice setting of their professional training program" and students were asked to submit written stories of their experience within the clinical setting (n=24). The data analysis method was described as hermeneutic utilizing content analysis within and between cases. The second stage of analysis used a matrix to compare separate cases across the two dimensions of practice, specifically: 1) expressed points of view and 2) expressions of performance.

Using the matrix the researchers identified three themes: the predominance of an instrumental perspective, a medical perspective towards practice, and a flat and fragmented perspective. The researchers stated that an instrumental practice orientation is

reflected in the students' step by step accounts of the performance of care with little mention of reflection, feelings, or ambivalences. Descriptions were often concerned with the actions of the student with little acknowledgement of the patient. As stated by the researchers, the accounts were based on actions rather than interactions, and were primarily accounts of self. In an instrumental view 'knowing that' trumps 'knowing how' and is based on outcomes rather than ongoing processes and links between means and ends such as the interactive process of caring.

Orland-Barak and Wilhelem (2005) attribute these results to the novice status of the students and the apprenticeship model of the particular nursing program. The account is limited in not including details of why these students are termed novices. Were they considered novices just on the basis of their student status and resultant lack of experience or were they novices in comparison to other students as well? While there is a very limited description of the apprenticeship model it is not a clear representation and there is no contrasting description of the constructivist-humanist model that is named in comparison and thus it is difficult to understand what the differences are in the models. In addition, it is possible that an interview format rather than a written account might have allowed the researchers to go beneath the initial statements of the students to gain a richer articulation of the background understandings of the student's experience.

Narrative pedagogy

Narrative pedagogy is a research perspective based on Heideggerian hermeneutical inquiry. The method seeks to address the complexities of both the educational and clinical environments in nursing education. It also uses critical, feminist, and conventional pedagogies with the intent "to gather and attend to community practices

in ways that hold everything open and problematic" (p. 3). After twelve years of study the researcher and her associates uncovered a recurrent category of Concernful Practices of Schooling Learning Teaching. These practices include: Gathering- bringing in and calling forth; Creating places- keeping open a future of possibility; Assembling- constructing and cultivating; Staying- knowing and connecting; Caring- engendering community; Interpreting- unlearning and becoming; presencing- attending and being open; Preserving reading, writing, thinking, and dialog; and Questioning- meaning and making visible. The following three studies are accounts of students in the clinical environment utilizing the assumptions of narrative pedagogy.

Ironsides (1999) presented a two year interpretive study of students and teachers (total n=45) to uncover the students' learning to think critically within concrete clinical situations, although critical thinking was not defined or articulated by the researcher. The prompt used to elicit students' responses was: "Tell me about your times with your clinical instructor this semester." An exemplar was presented in which a student compared her clinical interactions with two clinical instructors and their different teaching styles to facilitate thinking in a clinical context. One instructor involves the student in mutual explorations of practice towards extending the student's understandings of patient care. The student explained the instructor shared her thinking and figuratively stated, "she walks with you." The other instructor used a type of quizzing format that the student described as detached and analytic. The 'programmed' questions seemed to use a standard evaluation of course content rather than the particulars of the concrete situation.

In another study using narrative pedagogy (Ironside, Diekelmann, & Hirschmann, 2005a), the purpose was described as uncovering "how undergraduate students

experience making a difference in the practice setting." Again the researcher framed the research within narrative pedagogy and noted that the "Concernful Practice of Staying: Knowing and Connecting" was present in every student interview. While details of this pilot study were not given, the authors described an overall goal to uncover aspects of taken-for-granted nursing practice. The focus of the article is a long narrative by one student describing her care of a needy patient with multiple care issues. Ironsides interprets the student's account as making a difference during care by knowing and connecting with the patient. The student described the patient's situatedness of being resentful, anxious, frustrated, fearful, and generally overwhelmed by her care situation. By carefully listening to the patient's concerns and responding the student was able to organize her care differently and "keep[s] open a future of possibilities for caring" for the patient (p. 153).

Ironsides and colleagues published a second article (Ironside, Diekelmann, & Hirschmann, 2005b) reporting on results of a pilot study of students' clinical experiences. While both studies also report the use of interpretive phenomenology and a framework of narrative pedagogy, it is unclear whether these are reports from the same study and in each case how accounts were collected, how many subjects were involved in the study, and how data were analyzed. This particular account is framed in concerns that students receive adequate practice experience in the contemporary health care environment affected by more students vying for clinical spaces, a limited supply of clinical faculty, and additional factors within the clinical area that can lead to a suboptimal experience.

In particular, the account represents a student's response to witnessing a situation of depersonalized care by responding to "the call of the patient". The patient has been

described by nurses as a “frequent flyer” and a “a major pain in the gluteus maximus” yet, as described by the student and interpreted by the researchers the student responds to the patient’s call by personally connecting, maintaining an open mind, overcoming personal challenges, applying more than classroom content, and learning to listen.

A limitation of interpretive research is that is always partial and perspectival as is the distinguishing characteristic of all human research. There is no way to obtain that God’s eye view that would overcome perspective and partiality, both essential consequences of human embodiment and finitude. Any account necessarily leaves out aspects that might be captured by another perspective or approach. This particular interpretation did not resonate for me from my particular situated perspective. Instead I thought the detailed account by the student was self absorbed and did little to reveal the presence of the patient. In Benner, Tanner, and Chesla’s (1996) depiction of the call of the patient there is no expectation on the part of the caregiver of reciprocity whereas in this student’s account there is a sense that the student feels valorized and anticipates some ‘reward’ for her care of the patient and willingness to spend extra time with her.

Conclusion

These qualitative studies of undergraduate nursing students within the clinical environment reveal important aspects of the complex phenomenon of taking up the practice of nursing. Several significant themes were evident across the studies. One such theme was the interrelatedness and reciprocity of confidence and the increase in competence as one developed skills (Garrett, 2005; Haffer & Raingruber, 1998; M. M. R. Kosowski, 1995; Stockhausen, 2005; White, 2003). A lack of confidence in skills tended to cause preoccupation with performance and the possibility of making an error while

proficiency and competence in the doing of skills freed the student to then focus on the patient.

Another theme was the unanticipated emotional impact of taking up the practice of caring for the sick (Beck, 1993, , 1997; Cooper, Taft, & Thelan, 2005; Neill et al., 1998; Sedlak, 1997). Students often felt overwhelmed by their exposure to human suffering (Eifried, 2003). A related theme was the overwhelming sense of what is at stake in caring for the sick and vulnerable (Baxter & Rideout, 2006; Beck, 1993; Cooper, Taft, & Thelan, 2005; Haffer & Raingruber, 1998; Neill et al., 1998; Sedlak, 1997).Confronted with their own lack of agency, students felt anxious and fearful of making errors and harming patients as they found themselves in situations of uncertainty with little if any background skills and knowledge to guide their doing.

Connecting with the patient meant being open to understand what mattered to the patient (Cooper, Taft, & Thelan, 2005; Ironside, Diekelmann, & Hirschmann, 2005a, , 2005b; M. M. R. Kosowski, 1995; Sedlak, 1997; Stockhausen, 2005; White, 2003). Ways of connecting with the patient included envisioning possibilities for the patient (Eifried, 2003; Ironside, Diekelmann, & Hirschmann, 2005a; M. M. R. Kosowski, 1995), seeing the patient's and family's perspective (Cooper, Taft, & Thelan, 2005), learning the humility of caring and being with the patient (Stockhausen, 2005), and connecting the patient's past, present, and future (White, 2003).

Many students noted that their learning takes place alongside a nurse and that nurses made a difference in their experiences in both positive ways (M. M. R. Kosowski, 1995; Neill et al., 1998; Stockhausen, 2005; White, 2003) and negative ways such as feeling abandoned (Beck, 1993), or staff enacting sub optimal practices (Beck, 1993;

Cooper, Taft, & Thelan, 2005; Ironside, Diekelmann, & Hirschmann, 2005b). Support, encouragement, trust, and commitment on the part of the nurses were all mentioned as adding to the students' confidence, ability to learn and make decisions (Baxter & Rideout, 2006; Stockhausen, 2005; White, 2003). Clinical faculty as guides and mentors involve the student in mutual explorations of practice towards extending the student's understandings of patient care (Ironside, 1999). A unit culture reflecting an instrumental view of practice can influence students' learning towards a task based orientation with little acknowledgement of the patient as the focus of care (Orland-Barak & Wilhelem, 2005).

Each of these studies has contributed to increasing our understanding of the lived experience of student nurses during their clinical experiences. The research studies by Kosowski (1995), White (2003), Stockhausen (2005), and Haffer and Raingruber (1998) are especially useful since the researchers' interpretations give a holistic, contextual account of the nursing students' experiences. In contrast, other studies reduced the students' experiences into abstracted themes without a clear articulation of the phenomenon (Baxter & Rideout, 2006; Garrett, 2005; Neill et al., 1998; Orland-Barak & Wilhelem, 2005; Sedlak, 1997). Meaning is lost when a complex process is divided into segments. In fact, the brief excerpts of text from students' accounts give a richer sense of taking up the practice of nursing within the context of clinical care.

As the embodied model presented is a description of the expert nurse, the question arises how the student as novice can transform to an advanced beginner or competent nurse and how these transformations might be facilitated in nursing education. Nursing education tends to emphasize the formal and explicit knowledge, and leaves the

embodied taken-for-granted skills and knowledges of bedside nursing unattended or undescribed (Benner, Tanner, & Chesla, 1996). There is an obvious limit to formal theory that must be extended and contextualized through experience. Clinical concrete cases are always more complex, uncertain, and ambiguous than can be captured in theory, although theory can act as a guide, especially for the novice. Knowledge gained through experience broadens, extends, and refines existing knowledge and allows the fledgling practitioner to begin to recognize what is important in situations and compare situational similarities with prior experiences.

Dreyfus and Dreyfus (1996) acknowledge that even novices upon entry to nursing school have recognition abilities to draw on in clinical situations (the example used is noting what 'extreme agitation' looks like) based on their individual prior life experiences. Schools of nursing assume that students enter school with beginning skills of trust, involvement, and openness as part of their shared understanding of growing up in the culture (Benner, Tanner, & Chesla). But each of these skills which may or not be present upon entry into nursing school must be transformed and stretched to fit the new specific challenges and circumstances of being a nurse. Each of these everyday familiar and family skills are challenged by the context of health care settings and suffering and the skills must be adapted to meet the stranger instead of the familiar friend or family member. And they must be stretched to attend to high stakes situations and crisis that students may have little exposure to or experience with prior to nursing school.

A specific gap in the literature is the lack of research on second degree, master's entry nursing students' experience of taking up the practice of nursing. Given the survey type results of prior studies there is evidence that these students may well experience

their entry into and subsequent day to day clinical experiences differently than traditional baccalaureate entry students. How do their previous life experiences, education, and career choices influence the experience of second degree students? Master's entry into nursing programs tap into a new and highly talented student population, yet schools have not tailored their curricula to meet the needs of this richly experienced group. In addition, there has been no examination of the potential effects on learning of condensing and accelerating the curriculum as is requisite in second degree programs.

A phenomenological study of the lived experience of master's entry students can accommodate a range of experiential possibilities and include the day to day concerns of students within the clinical environment. As was articulated in the accompanying theory chapter, in most of the student's initial clinical encounters there is little that is ordinary or smooth flowing as the student tries to make his or her way through the new and unfamiliar clinical environment. Heidegger (Heidegger, 1927/1962) described this breakdown in taken-for-granted and non-reflective type engaged activity as unready-to-hand mode. A phenomenological account can serve to uncover and articulate how the second degree student with a variety of lived experiences in other fields varies the transitions between Heidegger's three modes of involvement that describe the individual's engaged stance within situations as the student takes up the shared skills, practices, and meanings embedded in the practice of nursing. Stories of practical experiences at the patient's bedside elicited during interviews allow the researcher access to the 'thrown' world of students.

Phenomenology as method strives to uncover and articulate the taken-for-granted and tacit meanings behind these skills and practices and their interconnectedness within

the practice of nursing and the taking up of that practice. The researcher provides a holistic account of the person in the situation and strives to describe and interpret what gets disclosed and what might have gotten covered over (Heidegger, 1927/1962). In addition, phenomenological research into the lived experience of second degree students can build on the reviewed studies of undergraduate students and uncover more of the background understandings that ground the taking up of the practice of nursing.

CHAPTER THREE

A fusion of horizons: Meaning and understanding

In becoming a nurse

The taking up of the practice of nursing occurs in a situated context that is rarely explicitly articulated and often taken for granted. Entering the clinical setting, nursing students encounter the juxtaposition of two worlds: one the medical and technological, and the other located in the local, meaningful, and unique world of the patient and family. For example, in the context of labor and delivery, nurses often administer highly technical interventions that require careful monitoring and management of dual patient (mother and fetus) responses. While the nurse must be concerned with the potential risks for both mothers and infants, she or he must also attend to the birth as a significant life passage for the patient, infant, and family.

My purpose in this chapter is to articulate the background meaning of taking up the practice of nursing in an experiential setting. This articulation is part of my current project, a phenomenological study of nursing students learning to become nurses in the hospital setting. Exemplar cases used to enhance this articulation of taking up the practice of nursing were collected while I was the faculty of record for clinical practica in maternal/child nursing. Clinical journals were written and collected as part of background coursework for the clinical experience, and students met in a postconference setting and were encouraged to provide narratives of their clinical day. Written permission from the students was gathered at that time to contact them in the future for consent to use the clinical journals in potential future research. Subsequent human subjects review was

obtained, students were re-contacted and formal written consents were obtained to use the students' narratives.

In part, learning the practice of nursing in a medical and technological world requires a 'fusion of horizons' (Gadamer, 1975/2004) as the lifeworld of student nurse intersects with the lifeworld and focal practices of patients and families. But it is not only these two horizons that are present; the technical understandings and practices related to medicalized birth as well as the structural aspects of a bureaucratic institution also shape the experiences of medical and nursing personnel, the student, and the patient and family members.

Gadamer (1975/2004) describes our gaining understanding as the fusion of horizons**.** Gadamer's horizon speaks to the limits of what can be seen from a particular vantage point. In an analogous form, one can picture a flooded rice field that visually appears as green stems poking up in clusters or clearings. Because of our background understandings of how the field would look if it wasn't flooded, we know that what appears as distinct clusters or clearings of green would be seen as a whole phenomenal field if the water was drained. In the same way, there are shared background understandings of whatever phenomenon one is engaged with that provides a relational context. The phenomenon is foreground, but it comes up from the context of a background that infuses it with meaning. Horizon is the limit of what one can see from one historical standpoint, but as one exposes and interprets more background meaning, the horizon changes and becomes clearer. In a comparable way, the intersecting worlds of students, patients, and westernized medicine can be viewed as sharing the same phenomenal field of background meanings.

Meanings and understanding

Human beings are born into a world that is already there, so that certain background meanings are both shared and tacit (Heidegger, 1927/1962). To Heidegger, each experience is understood based on our individual 'thrownness' --that is, our lived experience of being born into an existing culture. One's being is always situated in a particular community at a particular historical time (H. L. Dreyfus, 1994). Understanding is lived and "is itself a kind of practical experience in and of the world that, in part, constitutes the kinds of persons that we are in the world" (Schwandt, 2000, p. 196).

Being born into an already existing human world means that from the beginning humans are immersed in interpretive webs of practices that themselves contain interpretations about the human world. To be human is to interpret and to understand or encounter meaning (Gadamer, 1975/2004). A person cannot stand outside the hermeneutic circle of her or his preunderstandings (nor would she or he want to) to gain a more objective view. Background meanings condition our understandings and interpretations. In this way, learning is about taking up new interpretations, new meanings, and new ways of perceiving and acting as the student encounters ruptures his or her ordinary smooth flow of everyday being-in-the-world-as-student. Whatever is encountered in interpretation is encountered from within our background understandings, so it is always partial and temporary.

Meanings of practice

Becoming a nurse involves the taking up of a practice. A practice is not mere activity, but is a cluster of patterned and interrelated ways of being that relies on socially embedded practical knowledge (Dunne, 1997). The individual student as practitioner takes the most sensible actions in a particular situation of inescapable uncertainty, based on prior experiences and background cultural meanings. Nursing education tends to emphasize the formal and explicit knowledge, and leaves the embodied taken-for-granted skills and knowledges of bedside nursing unattended or undescribed (Benner, Tanner, & Chesla, 1996).

There is an obvious limit to formal theory that must be extended and contextualized through experience. Clinical concrete cases are always more complex, uncertain, and ambiguous than can be captured in theory, although theory can act as a guide, especially for the novice. Knowledge gained through experience broadens, extends, and refines existing knowledge and allows the fledgling practitioner to begin to recognize what is important in situations and compare situational similarities with prior experiences. Practices develop in response to "problematic situations of uncertainty, complexity, instability, uniqueness, and value conflict" (Schon, 1983, p. 117) but also in response to meanings and goals. Thus indeterminism and the ways that taken-for-granted background meanings cannot be made completely explicit limit the ability to formalize social practices (Benner & Wrubel, 1989; H. L. Dreyfus, 1999; Dunne, 1997) and knowledge gained through practical experience fills in the gaps.

One notices coherency and fluidity to a practitioner's use of shared goals, skills, knowledge, and equipment (Benner, 1997). For example, when an experienced nurse

enters a patient's room, she or he will notice in an embodied and non-reflective way salient aspects of the situation. The nurse will observe the patient's color, body posture and movement, level of consciousness, and a host of other aspects of the patient, all within the time it takes to walk to the patient's bed. In addition, the nurse will be scanning the room for equipment placement and functioning as well as other situational features that tacitly guide the nurse's further action. This is an example of taken-for-granted meanings, and skillful practices forming an embodied intentionality (Merleau-Ponty, 1945/2006). The nurse learns to dwell in a world that is salient for providing good nursing care.

Practices are also situated 'for the sake of' something else that is of concern to our *being* (Heidegger, 1927/1962). Practices as socially embedded human actions are defined by Alisdair MacIntyre (1984) as:

> [A]ny coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended. (p. 187)

Internal goods refer to social goods within the practice itself, while external goods refer to ulterior motives towards gains to practitioners outside the practice.

Human beings dwell in the world as concerned about, and caring for, people as well as objects (Heidegger, 1927/1962). According to Benner (1997), care ethics are embedded within the social community of nursing practice. Care ethics are situated, based in particular communal notions of the good and attentive to the needs, desires, and possibilities of the parties involved, in particular the patient and family members. Benner distinguishes the taking up of the *practice* of nursing from merely accomplishing tasks:

"Techniques or tasks completed without engaging in caring relationships with particular patients with particular sets of needs and concerns do not constitute a practice" (p. 50).

Communities of practice

Taking up a practice such as nursing occurs within a community of practice. Learning is situated and relational, and meanings are negotiated (Lave & Wenger, 2006). There is no discrete set of content that stands alone and apart from the practice setting. In the integrative learning of a social practice, notions of the good are also taken up in the formation of an everyday ethical comportment (Benner, 1997). For example, within a labor and delivery unit, nursing students learn to take cues from the particular patient regarding the meaning of modesty and the level of body exposure that is comfortable for the patient during labor, delivery, and the post partum period. As with any hospitalized patient, the student meets the patient in a vulnerable and exposed state of undress and the nurse and patient together constitute, typically in an unspoken manner, an understanding of what is meant by modesty.

For the nursing student, such learning is transformative, in that the new understanding or skill literally changes the individual's embodied ways of perceiving and orienting to the situation, as well as his or her set to act. Learning shifts from a focus on the individual to participation within a social world (Lave & Wenger, 2006). For the nursing student, world-transforming identity changes occur while taking up practical skills and knowledge through engagement within the everyday world of a community of practice and in encountering and caring for patients and families.

The nursing student and the phenomenon of care

Lived experience itself is interpretive. The meaning of our being and presence in the world is continually re-interpreted through our practical engagements with other people, things as equipment, and events that are of concern. According to Heidegger (1927/1962), caring in its broadest sense as 'things mattering' is essential to an understanding of human being. It is embedded in our every day involvements *in order to* and *for the sake of.* As a being that "belongs to involvements" the individual shares with others "a primordial familiarity with world" (p. 119), in which each is involved in the same concernful way.

To care about something or someone sets us up to act in certain ways based upon our care or concern related towards certain possibilities. We are drawn to act based on what we have already experienced. Growing up in a particular culture affords the nursing student access to an understanding of connection and involvement with the Other. The Other is always already there in the world in which we are born and raised. Heidegger (1927/1962) described the Other as:

> By 'Others' we do not mean everyone else but me- those over against whom the "I" stands put. They are rather those from whom, for the most part, one does *not* distinguish oneself- those among whom one is too…the 'too' means a sameness of Being as circumspectively concernful Being-in-the-world…Being-in is *Being-with* Others. (p. 154-155)

As social beings we are always already in a world with others and therefore have an existential readiness to deal with people as they go about their Being-in-the-World, Being-with is already there. We inhabit the world as a 'we'. Nursing students learn to understand the Other through the concrete experiences of being-with and caring-for the Other, a type of care that Heidegger referred to as solicitude. Solicitude in the everyday

world often shows up in a deficit mode as being without, being against or for, or passing by, but we come to know the other in our concernful solicitude towards them. The Being-with of solicitude is understood as a shared space of 'we' rather than 'you and I'. The Other is always there referentially, so that even in its absence it remains, although in the background of understanding as students encounter patients and their families in the clinical setting.

A postmodern/technological age

A cultural epoch, according to Heidegger (1952/1977), is comprised of any number of styles of understanding being, but typically one style becomes dominant and thus defines the age. Heidegger argues that "Metaphysics grounds an age, in that through a specific interpretation of what is and through a specific comprehension of truth it gives to that age the basis upon which it is essentially formed" (p. 115). This specific set of truth claims become the ways of interpreting and explaining the world. According to Heidegger, a culture's epochal style is so pervasive that it is invisible to its members. That is, the styles of a culture exist in practices, habits, equipment, skills, and social relationships. The style of a culture determines what shows up as important for its inhabitants. For example, one hundred years ago, gender socialization and expectations were so fully intertwined with economic structures and social practices that they were taken for granted and were seldom questioned socially. The notion of understanding *being* as human then fades into the background as a taken-for-granted way of being in the world is taken up, and takes over self-understanding. Therefore, taking up the practice of nursing in any historical time will reflect the style of that age and the style of the age influences what shows up as important to the nursing student as well as the faculty.

Beginning in 1950, later writing by Heidegger suggested that Western civilization had entered a new epoch: the technological understanding of being (H. L. Dreyfus & Spinosa, 2004). This new postmodern period is the age of possibilities. Everything, including human beings, is optimized. In television ads the Army encourages potential young enlistees to "Be all that you can be." Even children's lives are filled with sports, scouting, art and music lessons, and tutoring so they too can make the most of their possibilities. Adult individuals can 'reinvent' themselves or create or extend their identities via the web. The understanding of being has changed from an instrumental view to an informational view, or as suggested by Dreyfus and Spinosa, "the postmodern human being is not interested in collecting but is constituted by connecting" (p. 7). Now what matters is maximum flexibility or adaptability.

This new age of possibilities is distinctly different than the age preceding it in that human beings are no longer the subject in control of their destinies. Things are no longer regarded as objects but rather as "their ability to be used" (Heidegger, 1954/1977). Humans no longer stand apart as giving meaning as a subject in control of objects. Instead humans become resource, and along with every thing else, become "standing reserve" (Heidegger). Human beings as standing reserve are neither subject nor object but rather a placeholder in an enframing scheme. Persons as placeholders are not only interchangeable but in addition, the schematic itself becomes the ultimate affordance as offering an abstracted view of unlimited potential for flexibility or adaptability. For example, in the westernized managed care medical model, the patient might be conceptualized as "the hip in room 209" or "one of the anticipated discharges for the day". In each of these examples, goals, whether of profit or of care, can be lost within an

unthinking and routinized but efficient discharge of patients. The discharge routine becomes a thing unto itself, a structure without meaning other than a schematic of "available beds" on a supervisor's desk.

The technological style is about expediting, about furthering something else, about ensuring possibilities and unlocking the future. Everything that is summoned forth is put into a framework and is ordered, and can be reshuffled to extend possibilities (Heidegger, 1954/1977). Technology becomes organistic, a thing unto itself wherein meaning issues forth from the possibility of further reserves. The stem cell serves as the ultimate standing reserve. It represents total flexibility, standing by to become whatever we want it to be. We have resources that make possible "*endless* disaggregation, redistribution, and reaggregation *for its own sake*" (H. L. Dreyfus & Spinosa, 2004, p. 5). Thus, unwittingly, the reordering becomes the 'for-the-sake-of'.

According to Heidegger (1954/1977) the danger lies in the framework itself. In its organizing and reordering, the enframing becomes the style and thus is itself obscured from our view; there is no other meaning than future possibility. "We depend on technical devices; they even challenge us to ever greater advances. But suddenly and unaware we find ourselves so firmly shackled to these technical devices that we fall into bondage to them." (Heidegger, 1966, p. 54).

Ironically, as we depart from an age defined by the human control over the world picture, we enter a world that threatens our control and as Heidegger notes**,** "the will to mastery becomes all the more urgent the more technology threatens to slip from human control" (Heidegger, 1954/1977, p. 5). Yet Heidegger (1952/1977) suggests the answer to undoing the "grip of technology" is not in planning and calculation but rather in

becoming receptive to what is going on, "The closer we come to the danger, the more brightly do the ways into the saving power begin to shine and the more questioning we become" (1954/1977, p. 35). The focus on technology in modern healthcare settings can cause students to forget the lifeworld of patients. Yet patients and families engage caregivers through focal practices like birth that create a resistance to technology for its own sake.

Clearings and focal practices

According to Heidegger (1927/1962), human beings are always in the world within situations. Understandings of being are opened in clearings, which Heidegger defines as disclosive spaces or situations of shared human practices, traditions, and language. Within a clearing things show up in the light of our commonly held understanding of being so that individual interpretations have a "primordial familiarity" (Heidegger, 1927/1962). Clearings are situated so that they are always specific and therefore establish bounded possibilities. However, though 'situated', individual clearings are not spatial, but rather "a moving center of pragmatic activity in the midst of a shared world" (H. L. Dreyfus, 1991, p. 164). Heidegger addressed local clearings as temporary worlds gathered around everyday things and activities concerning the thing (H. L. Dreyfus & Spinosa, 2004). These gatherings around typical things and events serve to focus and sustain us around what matters to us in our local world. Possibilities show up as appropriate and "what particular possibilities are relevant is determined by the situation itself" (H. L. Dreyfus & Spinosa, 2004, p. 11).

Albert Borgman (1984) extends Heidegger's notion of local clearings to the idea of focal practices, events gathered on a 'thing' imbued with meanings from daily life

events. A focal practice signifies an orienting place that discloses, clarifies, articulates, and sustains the things that matter to those who are participants. Focal things and practices create a center of socially embedded meanings that radiate from the practice.

In Albert Borgmann's (1984) development of the notion of focal things and focal practices, the hearth is used as an exemplary focal thing. Focus, in Latin, means hearth. The hearth in Roman times was the gathering and centering place for family events. It was the site of daily practices as well as celebrations and religious rituals, in general, a focus of family activity. "The hearth sustained, ordered, and centered house and family" (Borgmann, p. 196).

Focal practices of family can be somber or celebratory. The following narrative, captured in the clinical journal of a nursing student, describes the particular focal practice of birth:

> The first thing I noticed was that the patient was very calm, had an oxygen mask on, and seemed very concentrated on her task at hand. She didn't look up or even open her eyes at the sound of our voices, and appeared fairly relaxed and not in any outstanding pain at the moment…We quickly found out that the patient was Spanish speaking only, but her husband understood enough English to help us get by. They wholeheartedly agreed to us being in the room and reality struck me that I might actually witness a birth today…
>
> After some time the nurse performed a vaginal exam and decided to have her start pushing…We instructed the patient on how to push and coached her through…Her husband was very supportive and stayed at her head, offering a lot of encouragement and touch, while the nurse stayed at the foot of the bed. The patient continued to remain very calm and reserved throughout pushing, but it was evident that she was getting very tired…She pushed through contractions for nearly two hours and started doubting herself and told her husband she couldn't do this anymore…At this point, the baby's head was in view, but not crowning enough to call the doctor in. It felt like we were stuck in the same spot for a long time…I couldn't help but compare this birth to the birth of my daughter. I pushed for 20 minutes and my daughter came into the world. I couldn't imagine pushing for two hours and still not being able to turn that last corner to the finish line. I could feel her pain and I wanted so badly to push and breathe with her.
>
> It felt like an eternity, but the doctor eventually came in and asked the patient if she wanted assistance in getting the baby out. She agreed to vacuum extraction and this decision really put things in motion! All of a sudden the peaceful five of us turned into a

buzzing 15+ people…It took about three good pushes and the baby's head came out followed by the body. It almost felt like everything went into slow motion as the baby came out…I could literally feel the relief from the mother as we heard some of her only words spoken the entire time…not just relief from the pushing and pain, but relief that she finally got to see her baby in person..

They announced that it was a girl and the new mom and dad were elated! Once the baby was stable, she was taken right to mom who immediately asked if she could put her on the breast. She held her and laughed, teared up, and looked at her husband. She was absolutely giddy with excitement, and couldn't get enough of her new baby. She passed her to dad, who beamed with absolute pride at the sight of his daughter.

…Later while the baby was receiving newborn care in the nursery…I noticed the father was trying to watch through the window and I asked permission to tell him the weight and height and what would be happening next with his baby…I asked if they had picked a name for her. He reached into his pocket and pulled out a piece of paper that his wife had written on: Bentazume. It was original to me, but special to them. I told him it was a beautiful name, congratulated him, and thanked him for the memorable experience.

One of the first things the student noticed was the patient's focused efforts on 'her task at hand', evidenced by her lack of acknowledgement of the presence of others in the room, not responding to sounds. The patient's husband gave support by his nearness at the head of the bed, his touch, and his words of encouragement. Though the patient did not show signs of 'outstanding' pain, after two hours of pushing her doubts whether she would be able to birth the baby created more of a focus of concern. The student had been drawn into the focal practice and recalled an altered sense of the passage of time. Time felt like 'an eternity'. She drew a comparison between this birth and her own experience of birth, another focal clearing. She related to the physicality of pushing in labor, much like an athletic event in which one 'turns the last corner to the finish line'. She vicariously felt the patient's pain and seemed to want to merge in a bodily way with the patient to push and breathe together. Thus rather than remain separated, the student maintained a position alongside. Similarly, she felt in an embodied way the physical relief of the patient following the birth.

The focal practice of birth seemed in jeopardy as 'the peaceful five of us' turned into a 'buzzing 15+ people', as additional medical personnel entered the room. Given the student's limited experience of coaching and supporting women in labor, she has no comparisons, and no suggestions of how the birthing might have proceeded in another manner. Rather, the student's narrative remained focused on the birth, as the mother greeted her new baby. Here one begins to experience the constituting of meaning of the new baby's 'world' as an 'elated' mother and father welcomed the announcement of a girl. The mother immediately sought to nourish and connect with the child; her emotions were heightened and abundant as she laughed, then became tearful. We notice the sharing of the event as she turned to her husband, and then later physically passed the new family member to him as he smiled proudly.

The focal practices of birthing, recognition, and naming continued in the nursery. The new family member was given a particular weight and height that would become part of the family's personal history of the birth event. Finally, the father produced a piece on paper on which had been inscribed the name of the child. The student acknowledged the name as unfamiliar to her, not a part of her world, yet she understood that the name had 'special' meaning to the mother and father. The particular name, as well as the height, weight, gender, and time of birth will be part of the 'always already' world of Bentazume.

The following narrative is an exemplar derived from another student's postconference account of a birth:

> As Rebecca sat listening to report with the nurse she was to follow during her first day in labor and delivery she realized that this was in fact a new world. Though she was in her sixth semester of a baccalaureate nursing program what she heard in report might as well have been given in Russian. Words and phrases like "milliunits per minute",

shrom (actually refers to the acronym for the spontaneous rupture of membranes, commonly known as the bag of waters breaking or leaking), and montevideo units were recalled as words in her theory book but had no meaning at this point in time. After report the nurse explained to her that the patient, pregnant with her first baby, had been scheduled for an induction of labor since she was nearly two weeks past her due date. The nurse further explained that the patient had received serial ultrasounds during the pregnancy since the baby was "IUGR" (intrauterine growth restriction) and they were "starting the 'pit' (pitocin administration to induce labor).

As Rebecca and the nurse entered the room the nurse suggested that Rebecca "ignore the machines since it's too much to explain" and "just focus on the family and support the patient in labor". Rebecca knew something about labor since she had coached her sister during the birth of her niece, and she had attended a childbirth class as part of her preparation for this semester's clinical focus. The patient was lying on her side with belts around her abdomen that seemed to tether her to the fetal heart monitor. Rebecca noticed two IVs infusing but the patient seemed to not be in pain. The student noticed an older woman in the corner, eyes closed and lips moving as though muttering a prayer. The patient apologized, saying, "my mother is praying for the safe birth of my son". Rebecca remarked, "oh, you know it's a boy?" and the patient proudly shared an ultrasound 'photo' in a frame on the bedside table. "This is our first picture of Bharav", said the patient with a wide smile. It seemed as though the patient had attempted to bring "home" to the hospital. She was dressed in a floral chenille robe over her hospital gown, and there were matching furry slippers beside the bed. There were framed photos of family members, a floral arrangement, and wrapped presents on the bedside table, a bouquet of balloons tied to the bedrail, and a teddy bear on the rocking chair beside the bed. According to the patient, her husband was outside talking on the cell phone "since they don't allow cell phones in the room". He was talking to relatives in Sri Lanka that were also anxiously awaiting the newest family member.

Whether by default or design, the nurse's instruction to focus on the family allowed the focal practice of birth within one family to emerge for the student. In part through the use of technologies such as cell phones, digital photos, and airplanes, the family is gathered and centered in the hospital room where the mother-to-be lies tethered to other technological devices. Technology has extended the range of this family's local world in both time and space. Even before birth the yet unborn child has been seen, gendered, and named, and the family is able to celebrate the birth with family in a distant country. The heightened sense of the importance of the event is represented in gifts and

symbolically decorated balloons, ties to home are present in the warm and comforting slippers and robe, and the patient's mother summons God to bless the event.

Birth in the age of technology

Nursing students entering the clinical environment face the real possibility of confusion concerning the relative importance of technology and its devices, in contrast to the local worlds and focal practices of patients. It is within the local world of a community of practice that the student takes up the practice of nursing. The community as well as the student dwells amidst a history and traditions that cannot be swept aside (Gadamer, 1975/2004). It is easy for the student to become confused in determining the 'for the sake of' in a culture of medicine with one foot in Heidegger's modern age of technical rationalism, and the other in his postmodern age, threatened by enframement of possibility for its own sake. Yet the student cannot escape his or her own history and traditions that form the background of understanding in which the student's clearings are/were created.

What is important in nursing care that attends to the lifeworld is that the student seeks to understand the relevant meanings of birthing and birthing focal practices of the family. The student is apt to lean toward technological enframing as a result of the clinic and schooling. However, in addition to technology and post-modern self-understandings, birthing practices as biographical, relational practices also shape the possible clearings and often constitute the focal practices of birthing for the mother and family.

In the postmodern world of hospitals, technological devices such as electronic fetal monitors and ultrasound machines can lure and focus attention on performance and possibilities rather than the disclosive space of focal practices of the human passage of

birth. The beguiling revealing of information can become activities that are self-defined and accounted for as mattering in a technical sense, rather than genuinely advancing the greater good of individuals and families. For example, surveillance devices such as ultrasound machines and fetal monitors have the potential to focus attention on information for its own sake and can distract the practitioner (doctor, nurse, or student nurse) from the patient as the focus of care. Within a technological understanding of medical care there exists a danger of closing off the focal practices of the family around health, illness, and birth.

What is the self-understanding of the person who can have a focal practice of birth that incorporates technology? Rather than seeing the technological understanding of birth and the focal practices of birth as two worlds in collision, the two can be articulated as a fusion of horizons that provides a clearing. In the cited exemplars, one can interpret the background meanings of what matters to the people involved. For example, since these families have chosen to give birth in the hospital, they believe in the modern westernized medical model and the safety of hospitals. From the standpoint of the medical personnel, the use of technology within medical practice stems from the same assumptions of what it means to be a person that is thrown within a peopled world in which what matters is a safe, medically uncomplicated birth for mother and infant**.**

Instead of viewing technology and nursing as opposing forces, technology can be taken up in a different way. Technology can be viewed as aiding our practical engagement and taken up as part of our concern for the patient. It helps us understand differently; a qualitatively different view of technology as part of the focal practice of birth that creates a focal clearing for us. In this way the technology "becomes embodied

in practical activity" (Walters, 1995, p. 341)—for example, as within the exemplar, the "baby photo" of the ultrasound (and thus the technology) was taken up as part of our concern for what matters to the patient while aiding the possibility of a safe birth.

The postmodern age affords nursing students access to devices such as simulators and the worldwide web that can enhance their learning. As Borgmann observes, "Technology can fulfill the promise of a new kind of freedom and richness. If our lives are centered in a focal concern, technology uniquely opens up the depth and extent of the world and allows us to be genuine world citizens" (Borgmann, 1984, p. 248).

In the first narrative, the student described how the patient's room was swiftly inhabited by over fifteen people after the application of a medical device, the vacuum extractor, was applied to assist in the delivery of the baby. For many of the medical personnel in attendance, perhaps this had become merely a technological medical event with little regard for the particularly situated focal practices of the family. However, the student remained in a shared, disclosive space with the family, articulating and sustaining the local meanings and the focal practices of birth.

In the second narrative, the strange language and equipment of the labor and delivery environment had the potential to lure the student from her attentiveness to the focal practice and towards a commodified view of the patient as standing reserve. In this view the patient would be nothing more than a notch on an experiential belt with perhaps some further information 'gain' of knowledge and skilled know-how about the technical aspects of medicalized birth. But the tradition of nursing practice strives to rescue, negotiate, and balance the focal practices and open the possibilities. Learning to strike the right balance is part of learning the practice. One does not discount technology, but

rather takes up the technology in such a way that it doesn't edge out the focal practices. This "rescue" is often thought of and called the art of nursing.

The possibility of other local worlds

As clinical faculty and nurses, we need to reflect on how we frame or open up clearings to students as they encounter the focal practices of patients and families from within today's culture of medicine. We need to keep open the possibility for other local worlds to show up alongside the dominant postmodern/technical paradigm. Gadamer (1975/2004) describes our gaining understanding as the fusion of horizons:

> Transposing ourselves consists neither in the empathy of one individual to another nor in subordinating another person to our standards; rather, it always involves rising to a higher universality that overcomes not only our own particularity but also that of the other. The concept of 'horizon' suggests itself because it expresses the superior breadth of vision that the person who is trying to understand must have. To acquire a horizon means that one learns to look beyond what is close at hand- not in order to look away from it but to see it better, within a larger whole and in truer proportion. (p. 304).

Gadamer's quote denies the personal subjectivity of empathy or the transposition of a mental representation such as a standard. Instead, his statement suggests a breadth of vision informed by "that region of lived experience where the phenomenon dwells in recognizable form" (van Manen, 1997, p. 397).

A centering force can be retained in focal things and practices. Technology in its transparency can be extending and revealing of our world. Borgmann suggests that " we remember and realize more fully that the technological environment heightens rather than denies the radiance of genuine focal things and … we learn to understand that focal things require a practice to prosper within" (1984, p. 196). A practice depends upon the

practitioner's practical engagement within a situation of meanings and concerns of individuals.

Engagement means to participate in a dialog with a world. As such, "engagement means risking one's stance and acknowledging the ongoing liminal experience of living between the familiar and strangeness" (Schwandt, 2000, p. 207). Familiarity and strangeness speaks to the individual's particular thrownness within a tacit phenomenal field of shared meanings. New experiences expand our horizons of understanding. Experiential learning as a new experience of meaning involves the rupture of prior understanding or ways of being in the world towards the development of new understanding. Meaning is negotiated rather than constructed (Gadamer, 1975/2004) in a dialog between our prejudgments based on the traditions into which we are thrown and the experiential "encounter with what is not understood" (Schwandt, 2000, p. 195).

The student exemplars presented here demonstrate the students' engagement or involvement with the Other within their focal practice of birth. In the first narrative the student admits the strangeness of the newborn's name of Bentazume, yet growing up in a commonly experienced world of concerns allows her familiarity with the meaning of naming and ushering a new being into a family. The concrete experience of Being-With the patient and family allows the student to expand his or her horizon to include what at first seems strange. Yet while there may be different notions of care for different cultures, as human beings we share the phenomenon of care (Heidegger, 1927/1962).

The potential exists to romanticize the language of focal practices and create a valorization or idealization in which one is a voyeur of someone else's experience. When reading the included exemplars, it is important to recall that focal practices are

spontaneous and fleeting. They are gatherings focused in a particular event and things. These interpretive accounts are perspectival, always partial, and reflect particular situations in time and space. Heidegger used the term "temporal determinateness" (Heidegger, 1927/1962, p. 40) to describe how in a moment of time, a limited number of possible standpoints are disclosed.

Caring practices in the postmodern

Caring practices in our postmodern technocratic culture can be invisible and marginalized. Their nearness to our being can cause them to be taken for granted or ignored, especially in a world where ends and means are often separated. Caring practices can be considered part of what Heidegger described as 'the saving power' of the little or humble things. Benner (2000) notes that caring practices that nurture other human beings preserve human worlds and concludes:

> All of the caring practices such as nursing, mothering, fathering, education, child care, care of the aged, social welfare, care of the earth may be potential saving practices even as they are threatened and marginalized by a society that creates myths about ever expanding possibilities to manage and control all aspects of life. (p. 309)

Nursing education often includes formal classroom time spent on topics of cultural competencies, therapeutic communication, and formal ethical theory; however, "theory is necessarily a skeletal, simplified version of reality" (Benner & Wrubel, 1989, p. 20). The dynamism, uncertainty, complexity, and indeterminacy of the human world of practice cannot be captured in theory or isolable, context-free rules. Theory can provide an outline and a sense of 'where to look,' but details must be filled out by experiencing a range of particular cases (Benner & Wrubel; H. L. Dreyfus, 1999). It is through the concrete experiences of Being-with patients and families that the student can rise to

Gadamer's higher universality and reach a superior breadth of vision (Gadamer, 1975/2004).

Learning everyday ethical comportment occurs through being-with the Other and staying open to an understanding of their focal practices as a centering force of what matters or a practice that gathers up meanings in their particular world. In the clinical environment the nursing student should be encouraged to remain open to the *what matters* in the patient/family lifeworld, the possibilities that people project onto their futures, and the ways in which they interpret the past. One of the challenges of nursing as a caring practice is to attend to the human experience of being ill or injured, giving birth, growing old, or facing death while skillfully using technology to create human possibilities and relationship. Artful use of technology will open up worlds or at least hold them open, rather than close them down and usurp the human significance of vulnerability, birth, growth and death. Human beings through their care allow other human beings to be recognized and met.

CHAPTER FOUR

Phenomenology as method

Practice professions such as nursing and medicine are often referred to as constituted by both art and science as if the skills of the practice reside on two sides of the brain. Though evidence based literature claims the practical reasoning for understanding *which* patient situation requires *what* relevant body of literature as well as the practical reasoning associated with adapting general evidence to the particular, often the evidence-based discourse reads as if it is a one to one correlation between the scientific evidence and the clinical judgments to be made. Kathryn Montgomery (2006) calls medicine "a rational practice based on a scientific education and sound clinical experience" (Montgomery, p. 30). While both medicine and nursing rely on scientific knowledge, the current emphasis on evidence based practices skews our understandings of practical thinking in transition within a situational context (Montgomery). In the real world of everyday practice of medicine or nursing, the individual practitioner hopefully takes the best action in a particular situation of inescapable uncertainty based on prior experiences and background cultural meanings as well as the best use of science and evidence based practice. At the very least the person takes the action most sensible to them at the time.

Dunne (1997) elucidates the relationship between practical reasoning (clinical judgment) and techne (that which is standardizeable and replicable) Both phronesis as practical knowledge and techne as technical standardizeable knowledge are articulated by Aristotle as distinct from theoretical knowledge. Techne is aligned to the making or production of things or towards outcomes according to prior specifications, thus techne is

applied to that which can be predicted and replicated. Techne refers to what can be standardized and generalized. Phronesis, on the other hand, is "more personal and experiential, more supple and less formulable, than the knowledge conferred by techne" (p. 10). It describes a modulation of practice that is nontechnical but not nonrational. Phronesis occurs in a practice, requires character, and skilled know-how in specific contexts..

The purpose of this chapter is to provide justification and description of interpretive phenomenology as the method used to study the lived experience of Masters Entry Program in Nursing (MEPN) students as they take up the practice of nursing. Specifically, I describe the grounding of the study in Heideggerian phenomenology, often referred to as hermeneutic or interpretive phenomenology. Several assumptions underlying the research methodology will first be explored as they are foundational to my methodological approach. These include: the relationship of Dasein to the world; the related notions of care, concern, and solicitude; and the hermeneutic circle and forestructure. These assumptions are derived from the work of Martin Heidegger (1927/1962) and Maurice Merleau-Ponty (1945/2006), with further development by Benner and Wrubel (1989), Packer and Addison (1989b); Dreyfus (1991), Benner (1994), and Leonard (1994). Following the articulation of my assumptions I will describe particular aspects of the research design and will end with the subject of the evaluation of interpretive accounts.

The accompanying chapter on the theoretical foundations for the study of the lived experience of nursing students provides a situated account of the constitutive world that nursing students live in during this century, in this culture, and in their lifeworld. In

encountering the nursing world, students' possibilities are framed by their particularly situated personal history. Students might be considered as entering the particular world of nursing as they take up the practice of nursing with all of the ambiguities and uncertainties that are part of learning a situated practice. Students encounter multiple worlds in new ways, as they take up the practice of nursing, the highly technical Western medical world with its rational technical underpinnings and devotion to high technology, a market driven world of health care, and the local lifeworlds of what matters to individual patients and families. To be involved in a human science (as is a nursing student), it is necessary to understand the meaning of social actions (Schwandt, 2000) as the student nurse must learn to make the best decisions in situations of ambiguity and uncertainty in relationship with others. It is never a question of judgment by fiat, but rather of mutual influence by patient and nurse.

Judgments under uncertainty are the heart of any professional practice. Background meanings condition our interpretations. In this way, taking up the practice of nursing is about interpretation as the student encounters ruptures in his or her ordinary smooth flow of everyday being-in-the-world-as-student (understanding), or is able to make sense of the new practice as a result of teaching and learning.

A human science such as research on nursing education is concerned with the embodied practices and concerns of students, patients, families, nurses, faculty, researchers, doctors, and other medical personnel. Traditional science is inappropriate for the human sciences that require an understanding of participant's meanings and interpretations as situated and engaged (H. L. Dreyfus, 1991; Heidegger, 1927/1962). In traditional science, the researcher attempts to be an uninvolved scientist contemplating

distinct objects separated from one's own existence. Rational Empiricism assumes the researcher can achieve an outside perspective that is objective and value free, what might be termed a God's eye view, or a "view from nowhere" (Nagel, 1986). In this view phenomena are decontextualized, broken down into atomistic, isolable units, abstracted and made ahistorical.

Heidegger's response was to shift from the problems of epistemology to the questions based in ontology: What is it to be human and how is the world intelligible to us at all? Heidegger noted that within epistemology, or the study of how we know the world, a theoretical account of knowing has most often been given priority. Heidegger takes issue with the notion that practical behavior can be described in terms of theoretical concerns; in other words, a rational-empirical account of practical behavior. Explicit, formal theory leaves out skilled-know how, the use of knowledge in specific situations, and tacit knowledge. Western culture has taken epistemology as primary while losing sight of the primordial nature of embodied unmediated encounters with the world and practical reasoning. Instead, within a hermeneutical account, practical behavior occurs from within our involvement in the world. The Heidegerrian view turns back from epistemological questions of our relation to knowledge or truth to instead address what we are as beings and how that affects our encounter, grasp and interpretation of the world. Hermeneutics "describe[s] our understanding of being from within that understanding without attempting to make our grasp of entities theoretically clear" (H. L. Dreyfus, 1991, p. 4).

Heidegger rejected the notion of the person as a subject separated from objects in the world. Instead, the self, or Dasein is a situated being which "finds 'itself' proximally

in what it does, uses, expects, avoids- in those things environmentally ready-to-hand with which it is proximally concerned" (Heidegger, 1927/1962, p. 155). As articulated by Heidegger, understanding is not a way of knowing about the world but rather is "a primordial familiarity with world" (Heidegger, 1927/1962, p. 119). Interpretive phenomenology does not provide a particular process, but rather is "working out the conditions on which the possibility of any ontological investigation depends"(Heidegger, 1927/1962, p. 62). The aim of phenomenology is articulation and understanding rather than explanation, prediction, or control. The goal of an interpretive account is to develop a thick description (Geertz, 1973/2000) that reveals a salient or significance laden articulation of the lived experience of the study phenomenon. The researcher provides a holistic account of the person in the situation and strives to describe and interpret what gets disclosed and what might have gotten covered over (Heidegger).

According to Hubert Dreyfus (1999), the three interrelated and foundational aspects of human intelligent behavior are: "the role of the body in organizing and unifying our experience of objects, the role of the situation in providing a background against which human behavior can be orderly without being rule-like, and finally the role of human purposes and needs in organizing the situation so that objects are recognized as relevant and accessible" (p.234). Everything that an individual does is based on a self interpretation of being in the world that is never fully objective and always involved (H. L. Dreyfus, 1994). We are drawn to act in certain ways based on what has already been experienced, while we project forward into a future of possibilities. In a comparable way there exist shared background understandings and newly formed meanings for nursing students that include skills and practices, how one encounters and uses objects and things

such as equipment, and how one relates to others. Phenomenology as method strives to uncover and articulate the taken-for-granted and shared meanings these skills and practices are constituted by and their interconnectedness within the practice of nursing and the taking up of that practice.

Interpretive assumptions

Dasein and world

Heidegger's articulation of Dasein's being in the world provides an orienting foundation for an interpretive account of any phenomenon; that is, humans' relatedness to, or dwelling in the world, is the context for any understanding of what it means to be human. Understanding is based upon taken for granted meanings, habits, and practices that reveal our ways of being and our understandings of our concerns and ways of being in the world. Our understanding of being itself occurs through our dwelling in and relationship with our world; we exist in a phenomenological paradox in that we both constitute our world and are in turn constituted by our world. The concept of thrownness describes our being born into a culture, family, and history of shared social practices that is always already there and forms our background understanding of ourselves and our world. Thrownness is our nonreflective taking up of world. We come to know the world through living in it rather than through mental representations of it. We come to know objects as things encountered for use within a culture. "Within this perspective we cannot define man or woman 'in him or herself' as separate from the way he or she occurs in and as world relationships" (Todres & Wheeler, 2001, p. 5). This structure of Dasein exists a priori and as a whole (Heidegger, 1927/1962). Koch described the relatedness between person and world as an "indissoluble unity" (1995, p. 831) to articulate how a person or

anything else is interpreted against a background of meanings. This utter relationality is radically different from the subject/object perspective of epistemology.

Care, concern, and solicitude

Lived experience itself is interpretive. The meaning of our being and presence in the world is continually re-interpreted through our practical engagements with other people, things as equipment, and events that are of concern. According to Heidegger (1927/1962) caring in its broadest sense is constituted by 'things mattering' Care or concern, in this ontological sense, is essential to an understanding of human being. "By working out the phenomenon of care, we have given ourselves an insight into the concrete constitution of existence" (p. 274). Our practical engagements are "life organizing self-interpretations" (H. L. Dreyfus, 1991, p. 96). Coping refers to an embodied intentionality that sets us up to respond to nuances in our environment in a particular way towards things and people that matter (Heidegger, 1927/1962; Merleau-Ponty, 1945/2006). Our coping and understanding of our world give us a sense of salience, and enable us to notice things that matter. As a being that "belongs to involvements", the individual shares with others "a primordial familiarity with world" (Heidegger, p. 119), each involved in the same concernful way. As social beings we are always already in a world with others and therefore have an existential readiness to deal with people as they go about their Being-in-the-World, thus Being-with is already there (H. L. Dreyfus, 1991; Heidegger, 1927/1962).

As noted by Benner and Wrubel "caring is always specific and relational" (1989, p. 3). Students must be connected and involved in a situation in order to notice either problems or solutions. It is within the particular interaction of the situation and the

historical features of the learner that experiential learning occurs (Benner, 1984). By studying students within concrete situations the researcher hopes to gain a richer understanding of how the student interprets and takes up the care, connection, and involvement that are at the heart of the practice of nursing.

To care about something or someone lets certain possibilities appear and set us up to act in certain ways. We are drawn to act in these certain ways based on our experiences in the context of shared social practices and common meanings. Caring practices are embedded in the notion of care as 'things mattering' to a person (Heidegger, 1927/1962). What we care about is evident in concrete practices, embedded in our everyday involvement rather than described as an attitude or belief (Chesla, 1991). As students enter the clinical world and take up the practice of nursing there are shared meanings, practices, and possibilities that can be uncovered through phenomenological study and interpretation. To study and interpret the lived experience of nursing students, we must " meet them 'at work', that is, primarily in their Being-in-the World" (p. 156), engaged in concrete practices; in this case, the clinical environment in which they take up the practice of nursing

The hermeneutic circle

The concept of the hermeneutic circle influences the methodological inquiry in every way. It forms the background understandings that ground the problematizing of the study, the research design, and the interpretation (Packer & Addison, 1989b). Methodological strategies, personal background, pre-understandings, and the historical social context all constitute the understandings and set to action or expectations that the person brings to the situation. Within the phenomenon of interest, as nursing students

enter the clinical setting, they encounter the juxtaposition of two worlds: one that is located in the postmodern and technological medical world as encountered in their particular clinical settings, and the other that is located in the local, shared and meaningful world of the patient and family. A phenomenological account can serve to uncover and articulate the interrelationships between the students' modes of involvements as the student takes up the shared skills, practices, and meanings embedded in the practice of nursing.

As a research methodology interpretive phenomenology is grounded in a nonfoundational approach and evaluation. Foundationalism assumes there are independent and objective truths outside of interpretation. In hermeneutic inquiry meaning is not derived from outside but rather from within a circle or clearing (Allen, 1995). The hermeneutic circle describes a circularity of understanding grounded in the threefold forestructure of forehaving, foresight, and foreconception (Heidegger, 1927/1962). One's forestructure is a way "into" the circle, a point of access. Forehaving refers to the background practices from our familiar worlds. Thus it describes the background practices of both the researcher and the participant (Leonard, 1994). This background gives us foresight which is a particular standpoint from which we interpret. Our forehaving and foresight give us some subjective anticipation of what we might see. Philosophical assumptions motivate and direct the researcher's methodological decisions (Lopez & Willis, 2004).

While descriptive phenomenology calls for the researcher to use a bracketing technique to set aside the researcher's preunderstandings, interpretive phenomenology considers this forestructure as essential in that it is the place from which one has a point

of view and from which the researcher can make meaningful distinctions in interpretation (Heidegger, 1927/1962; Packer & Addison, 1989; Leonard, 1994). Without preunderstandings, understanding is not accessible. A person cannot stand outside the hermeneutic circle (nor would she or he want to) to gain a more objective view. Whatever is encountered in interpretation is encountered from within our background understandings so it is always partial and temporary. Packer and Addison (1989b) described a forward arc in the research project that projects us towards possibilities in interpretation, and a backward arc of evaluation that brings us to a (hopefully) more fully articulated, plausible, and coherent answer to the original research question. In this way one can describe the hermeneutic circle as cycles of understanding, interpretation, and evaluation that brings us to a new understanding (Benner, 1994). The hermeneutic circle is a dialogical process (Cohen, Kahn, & Steeves, 2000) in that one's forestructure allows one to initially focus on data and then directs one towards particular possibilities from which one can dialogically reconsider and modify the preliminary (now outgrown) forestructure.

An interpretation is not just a description of events and phenomena, but is the working out of practical concerns and understanding from within a background of engaged, practical activity. Our direct practical engagement within a world of equipment and people is primordial for our tacit everyday understandings as well as the basis for our scientific knowledge and technological achievements. Heidegger describes the relationship between understanding and interpretation:

> In interpretation, understanding does not become something different. It becomes itself. Such interpretation is grounded existentially in understanding; the latter does not rise from the former. Nor is

> interpretation the acquiring of information about what is understood; it is rather the working out of possibilities projected in understanding (P.188-189).

When understanding is present explicit interpretations are not needed. Projecting forward towards possibilities means that understanding is always situated and is thus incomplete, perspectival, and in motion (Packer & Addison, 1989b). "Being situated means that we already understand who we are. This understanding is not cognitive but is lived" (Chesla, 1995, p. 66).

My forestructure of understanding

My research interest in the development of clinical judgment in nursing students and new nurses and the ways second degree nursing students take up the practice of nursing stems from my eighteen years of experience; working as a bedside nurse and charge nurse in a labor and delivery unit. As part of my duties I developed and organized preceptorships for new graduate nurses hired to the unit. The nuances of the perinatal environment require specialized training and applications of knowledge and all staff, from advanced beginner to expert, are expected to make safe, independent clinical judgments. Obstetrical nurses are responsible not only for the care and safety of the mother but the (dimly visible but palpably present) fetus as well.

In addition, the process of birth holds human personal and family meanings and expectations for the new family as well as their extended social and cultural groups. Hospitals are foreign places to healthy young parents-to-be. Media and social accounts of others' birth stories can influence the expectations of the new mother and the social support group that is usually nearby at the time of birth. With so much at stake, I often pondered how 'still green' new grads could manage this transformation in role, and why

it was that some graduates were successful and others were not. My forestructure led me to research the practical skills necessary for independent practice in new graduate nurses, from the perspective of the preceptors charged with their orientation in the labor and delivery environment (McNiesh, 2007).

Since 2003 I have worked as clinical faculty for three different nursing programs, all within the inpatient perinatal environment. I was struck by the inherent lack of preparedness for these clinical rotations since the students began their practica nearly always on the same week that they received their first background lecture on the specialty (and these typically started with conception!). I used the first hours of the first day as well as the first few post-conference sessions to fill in with the most significant "real time" background understandings that were necessary for their safe practice. I spent a great deal of time reflecting on what this information should be and what other safety measures I could utilize, such as spending their first shift alongside a nurse, distributing a list of "red flag" signs and symptoms for moms and babies, and demonstrating an initial baby exam with students on a one-to-one basis.

All of these experiences open the possibilities of what I might expect to see during interpretation of data:

> Interpretation is the working out of possibilities that have become apparent in a preliminary, dim understanding of events…and this preunderstanding embodies a certain concern, a kind of caring. It provides a way of reading, a preliminary initial accessibility, a stance or perspective (a fore-structure) that opens up the field being investigated. Interpretation operates within this initial way of understanding and reading. (Packer & Addison, 1989a, p. 277)

Nature of the study

Qualitative studies provide in depth, rich descriptions of the phenomenon of interest. Such studies are especially useful when confronted with a complex human activity such as nursing practice. The overall goal of this qualitative research study was to articulate the background understanding of how students experientially take up the practice of nursing within the clinical setting. What are the situated possibilities, activities, and engaged practical reasoning that the student constitutes and is constituted by in the nursing student's world? Specific aims included: What pivotal formative experiences do students identify as helping them develop and differentiate their clinical practice, form their capacity to act, and their identity as a nurse? What is ambiguous and what is clear to nursing students within the clinical situation and how does that change over time? How does "the press of the situation" (Benner, Tanner, & Chesla, 1996, p. 365) affect the student's performance? How does their background experience differentially affect their clinical learning and how does that change over time?

The culture that forms among students who are learning to think like a nurse is an example of an 'undiscovered culture' (Speziale & Carpenter, 2003) within the every day practice of nursing. Tacit knowledge is information shared by the culture that is implicit and taken-for-granted by those who share the culture. Through phenomenological interpretation we can describe and articulate the meaning of the nursing students' lived experience of learning. The hermeneutic, or interpretive tradition of qualitative research suggests that one can access and interpret a culture through the experiences of individuals within the culture (Polit & Hungler, 1999). This works because cultural meanings are social, shared and form a common taken-for-granted access to the situation. Shared

background meanings do not render sameness or lack of disagreement. Rather they make disagreement possible in particular situations. For example, the meanings of gratuities or tipping in a restaurant may be shared without holding to the same percentages or whether absence of tipping is warranted by poor service. Interpretation uncovers or reveals meaning between the researcher and the informants (Agar, 1999) as each informant gives access and helps articulate the situation within a whole culture. "The participant's voice is not a privatized, purely subjective voice but rather an embodiment and lived understanding of a world and set of local clearings created by social groups, practices, skills, history, and situated events" (Benner, 1994, pp. 100-101). In this way, we can make what is implicit in the students' culture at least partly explicit (Hammersly & Atkinson, 2005), and almost always more intelligible and understandable.

Study procedures

Institutional approval

This study was submitted to and subsequently approved by the Committee on Human Research (# H12251-229277-02A) at the University of California, San Francisco. Informed consent was obtained from participants for interviews as well as clinical observations. (See Appendix A)

Sample

Students from a master's entry program in nursing (MEPN) were purposively recruited for this study of how nursing students experientially learn to be nurses. This is an accelerated program located in the western region of the U.S. in which students with non-nursing baccalaureate degrees take foundational nurses courses and clinical practica, and are then eligible to sit for their NCLEX exam at the end of one year of study.

Subsequently students enter two years of advanced practice study, although many students opt to "step out" and practice nursing for a year before re-entering the program. As second degree students in an accelerated program, the MEPN students allow a different point of access to articulate how students take up the practice of nursing. The MEPN has rigorous admission requirements and attracts highly verbal and accomplished students. Qualitative research is enhanced by the selection of informants that are able to clearly articulate their experiences. In addition, the MEPN students reflect the ethnic diversity of the region where the program is located.

Eligibility was limited to English speaking students in the first year of the master's entry program in nursing (MEPN) at the specified research site that were currently enrolled in a clinical practicum and agreed to participate in the study. As more applicants were available than the target number desired, the investigator chose subjects based on achieving a maximum representation along gender, racial, and ethnic categories as well as background experiences of educational, employment, and other personal factors. Achieving diversity in the sample is not essential for an interpretive study, however it can provide a broader range of standpoints from which a particular experience can be told (van Manen, 1990).

The sample included seventeen females and two males. Ethnicities represented included African American (1), Asian (Chinese,Vietnamese, Filopino-5), Caucasian (11) , mixed ancestry (1), and one respondent who declined to state (N=19). Participants ranged in age from 24 to 50, with an average age of 30. All held undergraduate degrees and three held graduate degrees as well. Majors studied included (but not limited to) art history, biochemistry, international relations, literature, psychology, and sociology. Job

experience included (but not limited to) actor, statistician, teacher, web producer/editor, paramedic, and chemist. Five had prior experience in health care and three had experience as a patient with a chronic or serious illness. The majority included evidence of volunteer work and service in their applications.

Entrée

The researcher recruited participants by presenting the research proposal at the end of a class session for first year MEPN students (with prior agreement from the clinical professor and invitation to the students). Information about the research purpose and design as well as potential risks and benefits for participants was given at that time and students received this information in written form as well. Students were encouraged to ask questions and invited to participate in the study. Students were given information to contact the investigator if they were interested in participation and students were also given the choice to enroll at the time of the presentation. Volunteers for participation were contacted by phone or email, as requested by the individual participant.

Data collection

While aspects of the study, such as data collection and data analysis are described in separate sections of this chapter, it is important to emphasize that interpretive inquiry is iterative in nature so that procedures occur nonlinearly and at times simultaneously. For example, interview questions were guided by the practices and concerns of the students disclosed during the interview and thereby new lines of inquiry were opened between subsequent interviews. Evaluation of interpretation occurred during interviews as the researcher verified her understanding of participant's statements by asking clarifying questions.

Interviews. Audiotaped, semi-structured interviews with nursing students in the Master's Entry Nursing Program as well as participant observations of students in their clinical roles were the major data collection strategies. Interviews were conducted in a private setting at a time and place convenient to the participants. During interviews, the researcher attempted to make the environment informal and comfortable. The researcher explained the purpose of the research and encouraged the participant to answer questions as fully as possible, emphasizing that there were no "wrong" responses to questions. Prior to the interview, the researcher provided verbal and written informed consent and then asked for permission to audiotape the interview. Participants were asked to engage in 4 interviews over the course of their first year of study. In this way the researcher endeavored to capture transitions in the taking up of the practice over time. If more information seemed warranted at the end of the study, the investigator would ask the participants' permission to re-contact them following CHR approval of further interviews.

A total of nineteen students participated in interviews and all students provided background questionnaires of demographic information, education, and prior employment experiences (Appendix B). During the prior year four students in their first year of study participated in individual interviews throughout the school year. Three of these students were interviewed on four occasions; the fourth person was interviewed only three tines due to a difficult family circumstance. Fifteen first year students were interviewed throughout this current school year using both individual and group (3-4 participants) interview formats, for a total of 4 interviews per participant (Appendices C and D). Interviews lasted from 60- 90 minutes.

As much as possible during interviews students were asked to retell a story about their involvement in actual situations of care. Stories of practical experiences at the patient's bedside elicited during interviews allow the researcher access to the 'thrown' world of students. Benner, Hooper-Kyriakidis, and Stannard (1999) consider narratives as a particularly effective strategy to access the experiential learning of individuals in clinical settings since they give a sense of time, place, and characters within the story and capture what was important to the teller. The story is recounted in everyday language replete with multiple meanings, nuances, and ambiguity (Chesla, 1995).

Stories coherently reveal how individuals understand their worlds. Narratives give the researcher access to particulars and direct us to what matters to the informant (Benner, Tanner, & Chesla, 1996). The participants' concerns organize their stories. Narratives are situated within a particular social and historical time and are told "within the context of cultural narratives which delimit what can be said, what stories can be told, what will count as meaningful, and what will count as nonsensical" (S. Lawler, 2002, pp. 242-243). Cultural common meanings constitute the person's possible narrative and perspectives. By thematic interpretation of the narratives one can understand the 'lived' experiential learning of the student within the clinical environment and thus gain more knowledge about the culture of nursing students.

Observations. Field observations of students engaged in the care of patients can bring forth background details that remain hidden to students within their tacit understanding of care (Benner, Tanner, & Chesla, 1996). Thus observations provide an additional source of articulating the students' taking up the practice since their narrative accounts within the interview setting could well preclude these details. Observations were

optional but welcomed. While conducting a pilot study for this project I was told by a few of the participants that some students chose not to participate in the study specifically because of their unwillingness to be observed. During the recruitment phase I emphasized that the nature of the observation was for my understanding of their practical engagement and not of an evaluative nature and that if a student was still anxious about being observed he or she could be included in the interview portions only.

Students were notified of a pending observation at least twenty four hours prior to the clinical practicum. The researcher again asked for verbal consent just prior to observations in the clinical setting and reminded the student of the purpose of the study to differentiate it from a "testing" scenario. This included an assurance that no information about student performance during the observation would be communicated to the course instructor. However, if there was a blatant act of unsafe action on the part of the student the researcher would interrupt the student on behalf of the patient. Before either interviews or observations students were reminded that their participation was voluntary for that particular day and for the study as a whole.

Six students were observed during engaged activities of their clinical practica. These observations lasted 2-3 hours. Upon my arrival on the unit I asked the student to give me a report on their patient's status and history similar to what they have witnessed in the hand off report by nurses. I made notes of the physical environment, the equipment in use (in a broader Heideggerian sense, the relationships with people, and the mood/tone/press of the situation (Benner, Tanner, & Chesla, 1996). During these observations I discussed with the students their specific actions and routines as well as their practical reasoning while giving care to patients. Dialog with participants while

they are engaging in their everyday activities can give the researcher closer access to their practical reasoning and concerns as the situation develops (Benner, Tanner, & Chesla). Field notes and notes from the participant observations were used as text in the interpretive analysis and opened up a greater background understanding of the context of care.

Issues of confidentiality and privacy

No identifying or health information about the patient or other non-enrolled participants was collected. Before the researcher arrived to conduct observations, the student-participant presented her or his patient with a study information sheet and answered any questions the patient might have had. The student then asked the patient for verbal consent for the researcher to observe the student while at the patient's bedside. This maintained the patient's privacy while he or she decided whether or not to allow the researcher to observe the student performing care within the patient's room.

Interviews with participants were conducted in a private, confidential setting. All audiotapes were destroyed upon completion of the study and remained in a secure area until that time. Transcriptions and other data have been de-identified. Identifying documents were separated from the data, stored in a secure location, and destroyed at the completion of the study.

Data Analysis

Data analysis occurred continuously and simultaneously with data collection using interpretive phenomenological approaches. The text of the interviews was transcribed verbatim, and listened to not only to verify the accuracy of the text but also to note pauses, inflections, or silences as these might signal areas of meaning that have been

covered over. Analysis began by reading through the entire interview, field notes, and other background information to get a sense of the whole. "The researcher begins with a vague and tentative notion of the meaning of the whole of the data and with the reflexive awareness that this notion is an anticipation of meaning" (Cohen, Kahn, & Steeves, 2000, p. 72). One should remain aware that the participant's original telling in narrative form, the recording of that data, the re-telling by the researcher, and the ultimate reading by others are all interpretations of the phenomenon (Benner, 1985; Koch, 1996). Interpretive notes were written during and after each reading of the narrative text.

Interpretation proceeds by moving back and forth between parts and whole, between forestructure and what is being revealed (Geertz, 1973/2000). The whole is examined in light of what is understood from the part and vice versa. Writing simple descriptions of what is happening points to the concerns and possibilities in the action as well as what seems conspicuously missing or disturbing (Packer, 1989). Staying close to the lived experience helps avoid false or wrong-headed biases (Benner, 1985) while stepping back to view the big picture of how the individual narrative helps clarify the phenomenon. The researcher approaches the reading in a curious and non-judgmental way (Chesla, 1995). Transcriptions were read keeping in mind the initial research question and aims as well as the following framing questions: What narratives does the researcher feel obligated to articulate because of its particular resonance? What findings are present that were not anticipated? What seems unclear or absent? These situations of breakdown when reflected upon as part and whole are then no longer a part of the background understanding and can give access to what is usually covered over and taken for granted (Benner, Tanner, & Chesla, 1996; Packer & Addison, 1989a).

Specific narratives that demonstrated the concerns of the informants were identified and interpreted. In the same manner that shared social meanings allow us to understand the flow of a conversation, in interpreting narrative texts "we recognize the kind of situation people are acting in and the concerns and involvements their activities embody" (Packer, 1989, p. 111). As initial interviews were interpreted lines of inquiry were delineated and these were integrated into subsequent interviews.

After reading all texts, the researcher became immersed in the data for overall feel, "questioning, comparing, and imaginatively dwelling in their situations" (Benner, 1994, p. 99). During both the interview and data analysis phases, an open dialog continues between the researcher as self and the participants' voices. It is anticipated that there is movement in understanding through time and the researcher needs to keep track of these transitions in understanding (Benner, 1994). During my research these transitions in understanding often occurred while not actively engaged with the data, but rather during a non-structured, pensive part of my day.

A paradigm case, defined as "a strong instance of particular pattern of concerns, ways of being in the world, or ways of working out a practice" (Benner, Tanner, & Chesla, 1996), allows other less obvious instances with similar characteristics to be recognized in relation to it. Early in interpretation paradigm cases may stand out without the researcher being able to articulate why or what. Features of the paradigm case can be better articulated through comparison with other cases. An exemplar, though smaller than a paradigm case, is a "strong instance of a particularly meaningful transaction, intention, or capacity" (p. 10), a vignette that captures the meaning of a situation. Exemplars are useful to illustrate qualitative distinctions both within and between themes (Benner,

1994). As with paradigm cases, exemplars can be used as strategies for explicating shared meanings within the culture. During early readings I placed "stand out" narratives in a particular Word folder for subsequent interpretation and comparison.

With each reading of interviews I searched for themes and meanings between individual students' narratives. An important aspect of earlier reading was to hold open my interpretations and to consider themes as temporary placeholders for the location of data in Word files. Thus I could compare text from different interviews within a "themed" Word file without the theme itself being highlighted and always open to change.

Subsequent thematic analysis interpreted the common threads of meaning, comparing the literal meanings of the participant's words to developing themes, as influenced by my changing forestructure. Exemplars and paradigm cases offer embodied examples of meanings embedded in a shared culture (Benner, 1985). By articulation of paradigm cases, exemplars, and thematic interpretation of the narratives one can understand the experiential learning of the student as lived within the concrete cases of the clinical environment.

Writing the interpretation

The hermeneutic circle continued in the process of writing and re-writing in which this researcher continually reflected on her transformations in understanding. As noted, the researcher should expect her understandings to be upended or extended numerous times during the discovery phase that is data analysis. This researcher anticipated that her forestructure would be modified.

This description of a forward arc of uncovering explicates how the hermeneutic circle is not viciously infinitely circular; the arc projects forward in a movement in

understanding rather than a reiterating of the researcher's initial forestructure (Packer & Addison, 1989b). Advances and regresses in understanding are made as one moves from a tentative inchoate understanding to a clearer grasp of the situation; regressions occur when the situation becomes less accessible and less intelligible as a result of the interpreter's understanding (Taylor, 1993).

Writing can illuminate and give resonance to an interpretation. In writing interpretive results the researcher pays special attention to not only "what" the account is about but also "how" the text speaks (van Manen, 1997). In stating, "poetry is the thickening of language" (1997, p. 345), van Manen alludes to the ability of the imagery of language to gain an immediate access to the commonalities of everyday experience. These create "images and sensibilities that are so crisp and real that they in turn evoke reflective responses such as wondering, questioning, or understanding" (p. 354). Concreteness, evocation, intensification, tone, and epiphany are all attributes of an imaginative use of language that pull us into a text and allow the experience to resonate (van Manen). Such writing strikes and validates a common cord of experience. This research was clearly enhanced by the articulate voices of the participants.

In discussing the phenomenon of language Taylor (1985) describes a function of language as bringing matters into a public space where the subject or feeling becomes a matter of concern for us together and serves to create a rapport between us based on this thing that matters to us. "Language creates what one might call a public space, or common vantage point from which we survey the world together" (p. 259). In contrast to the notion of communication which assumes the transmittal of information of knowledge

or belief between individual knowers, the notion of a public space rather describes a place of focusing together on a common concern.

"The aim is to construct an animating, evocative description (text) of human actions, behaviors, intentions, and experiences as we meet them in their lifeworld" (van Manen, 1990, p. 19) "so that in the words, or perhaps better, in spite of the words, we find 'memories' that paradoxically we never thought or felt before" (p. 13). In this way, the researcher portrays a partial and temporary account that provides a family resemblance with future or other possible accounts. A good account exposes ambiguity in uncovering a range of perspectives from which a phenomenon can be viewed (Packer, 1989). An interpretation is a disclosure of what is already there (Heidegger, 1927/1962), of the structures of meaning in lived experience that are preverbal and nonreflective and thus difficult to describe. It makes clearer and more perspicuous what is already understood. Thus the person does not "make" meaning but rather uncovers it. The goal is to reach an "inside out" view of the experience (Benner, Tanner, & Chesla, 1996; van Manen, 1990).

Within a practice, and the taking up of a practice, there is always more background meaning to uncover due to the complexity and dynamic changes over time that occur in any clinical situation. The background understandings of a culture are always already there and act to illuminate what stands out as mattering in a culture; it is the background that allows one to perceive and focus on the foreground (Merleau-Ponty, 1945/2006). Thus what can be uncovered and made explicit, intelligible, and accessible remains partial.

Evaluation

There cannot be an outside representation from which to judge the validity of the interpretation (Benner, 1994; Packer & Addison, 1989b). Instead of seeking an outside value free foundational perspective, the researcher using interpretive phenomenology seeks a stronger and finer articulation of the phenomenon of interest from within the structures of meaning in lived experience. The phenomenologist's account does not present the reader with theory, conclusive arguments but instead a plausible and coherent account of the multiple interpretations of meaning.

Uncovering is part of the return arc (Packer & Addison, 1989a) in exposing whether the inquiry in fact answered the researcher's practical and engaged question that initiated the research. One does not seek a single truth or an account of how things really are but rather a possible solution to the problem as originally formulated in the research question as a confusion, cloudiness, concern, or disturbance in understanding. Interpretation stems from the researcher's engaged concern and "a true interpretive account is one that helps us and the people we study, that furthers our concerns" (Packer & Addison, 1989a, p. 281).

Evaluation of interpretive accounts continues to be a subject of controversy (Annells, 1999; Koch, 1996; J. Lawler, 1998; Maggs-Rapport, 2001). Packer and Addison (1989a) suggest that any evaluation is, in varying degrees, "a hidden application of the correspondence theory of truth" (p. 276) in seeking validation outside the account itself. Benner (1994) posits that this is not correspondence, but rather a shared understanding achieved by the participation in shared meanings and clearings or disclosive spaces. Van Manen suggests use of the term "expressions of rigor" rather than

criteria to differentiate how one can evaluate an interpretive account without using external validation (1990).

Koch (1996) considers three central issues that legitimate interpretive research to be: philosophy, rigor, and representation. Philosophical underpinnings should be clear and the assumptions should be evident throughout the account. Rigor indicates that the trustworthiness of the account is established. The clear participation of the researcher in the production of the account creates maximum grasp or understanding by the reader (Chan, 2005; Merleau-Ponty, 1945/2006). For the interpretive phenomenologist this occurs through the initial description of one's forestructure of understanding, followed by frequent reflection and dwelling with the data during interpretation to discover the influence of one's own forestructure on the articulation of findings.

Following a critical analysis of rigor in interpretive phenomenological research, deWitt and Ploeg (2006) suggested an evaluation schema that includes: balanced integration, openness, concreteness, resonance, and actualization. Balanced integration includes the interweaving of philosophical underpinnings throughout the study that articulates how the philosophy fits the researcher and research question. Balanced integration means the account also provides a balanced representation between philosophical discussions and the voices of the informants. The interpretation might also include an explication of the merging of views as the phenomenological account is based on a negotiated interpretation between the researcher and informant.

Openness includes the systematic explication of methodological decisions. For example, a decision trail based on theoretical, philosophical, and methodological choices can be used to clarify the research process and lay it open to understanding (Koch, 1996).

Concreteness describes the practical usefulness of study findings, something van Manen (1997, p. 351) refers to as "lived throughness". The reader is able recognize it as a shared experience and to situate himself or herself within the context, while also linking it to experiences in their own lifeworlds. It is a lived experience to be understood in concrete circumstances.

Resonance refers to the account's evocative effect on the reader. Resonance not only refers to a cognitive account revealing taken for granted or hidden meanings of human experience but a direct access to recognition and experience of the phenomenon. In part, the power of the text is energized by "an irrevocable tension between what is unique and what is shared, between particular and transcendent meaning, and between the reflective and prereflective spheres of the lifeworld" (van Manen, 1997, p. 346).

Actualization addresses the possibility for the interpretation to resonate in the future. While a phenomenological account is written and then read at particular times the account can continue to be interpreted in the future. Balanced integration and openness are concerned with the research process while concreteness, resonance, and actualization are expressions of rigor to evaluate the account.

The interpretive researcher assumes that colleagues share cultural meanings and can thus serve as other readers to help illuminate an interpretation of the phenomenon (Benner, 1985). Other interpretive researchers as well as research participants provide multiple vantage points from which to view the phenomenon. Sharing interpretive accounts with other phenomenological researchers should not be confused with the outside foundational practice of member checking. Member checking as a foundational practice assumes that there is an objective standard against which the phenomenon can be

evaluated. Instead, an interpretation should make sense and reveal more of the covered over practices to other researchers. Sharing interpretive accounts should more resemble dialog rather than interpretation-free evaluation or resorting to imagined foundational certainties (Packer & Addison, 1989a). Early in this project interpretive accounts were shared with fellow students involved in phenomenological research. Later in the project exemplars were shared with my faculty adviser.

Phenomenology captures and acknowledges movement, uncertainty, and ambiguity. The interpretive account is perspectival, always partial, and reflects a particular situation in time and space. In the interpretive account Heidegger used the term "temporal determinateness" (Heidegger, 1927/1962, p. 40) to describe how in a moment of time a limited number of possible standpoints are disclosed. In this way the researcher presents only a partial view of the possibilities in the situation. "We can understand phenomenology only by seizing upon it as a possibility" (Heidegger, p. 63); not as a certainty. The 'ending' in the writing of an interpretive account is "tentative and historically bound" (Cohen, Kahn, & Steeves, 2000, p. 71). As well, the final interpretation of any text is made by the reader (Diekelmann & Ironside, 1998) yet this in itself is temporally bound.

CHAPTER FIVE

Situational aspects in the background of an accelerated and condensed nursing program

Background

Accelerated nursing programs are becoming commonplace in response to the interest of second baccalaureate degree students in nursing and the nursing shortage. According to the American Association of Colleges of Nursing (2005), accelerated BSN programs are the fastest growing type of entry level nursing programs in the US. Though not as prolific, as of a 2007 survey by AACN (American Association of Colleges of Nursing, 2007) there were 56 master's entry nursing programs nationwide and 13 more were in the planning stages. Masters entry programs are appealing to those with non-nursing baccalaureate degrees and prior career trajectories since these programs build on these former skill sets and allow students to jumpstart and enter the field as advanced practice nurses. There has been little research on accelerated nursing programs in general, and only a fraction of these have focused on master's entry nursing programs. These programs tap into a new and highly talented student population, yet many schools have not tailored their curricula to meet the needs of this richly experienced group.

The education of professionals requires attention to intellectual, practical, and ethical aspects of the role. The social contract between the public and the professions inscribes a duty to serve the interests of both the individual and the society. According to Gardner and Shulman, the six 'commonplaces' of the professions include:

> a commitment to serve in the interests of clients in particular and the welfare of society in general; a body of theory or specialized knowledge with its own principles of growth and reorganization; a specialized set of professional skills, practices, and performances unique to the profession; the developed

> capacity to render judgments with integrity under conditions of both technical and ethical uncertainty; an organized approach to learning from experience both individually and collectively and, thus, of growing new knowledge from the contexts of practice; and the development of a professional community responsible for the oversight and monitoring of quality in both practice and professional education.(p. 16)

Learning the practice of nursing occurs in a situated context that is rarely articulated because it most typically operates in a taken for granted and well-established background. Becoming a nurse is situated in taking up a practice that relies on socially embedded practical knowledge (Dunne, 1997). Judgments under uncertainty are the heart of any professional practice. A gap exists in our informed understanding of the nursing student's experiential journey to learn the knowledge, skills, and attitudes that form clinical competency, the context of patient care where this occurs, and how it reflects on the shared cultural knowledge of nursing students and our anecdotal grasp of these complexities.

Literature review

There have been no national studies comparing accelerated programs since the first survey research in 1992 (Wu & Connelly, 1992). Demographic and descriptive data from a number of single site studies were found as well as a report from AACN (2005) on second degree programs that utilized data from interviews with representatives from schools and health systems within their network. No survey information was found that targeted students enrolled in master's entry nursing programs. More recently Cangelosi and Whitt (2005) published a literature review of research on accelerated programs, however the researchers only cited articles on BSN programs and only eight research studies were found.

Survey results noted that the percentage of male students in second degree programs was more than twice as high as the percentage of male students in traditional programs (Meyer, Hoover, & Maposa, 2005; Seldomridge & DiBartolo, 2005; Wu & Connelly, 1992). Accelerated students were typically self-motivated (Meyer, Hoover, & Maposa, 2005; Miklancie & Davis, 2005; Vinal & Whitman, 1994) had a variety of life experiences (American Association of Colleges of Nursing, 2005; Shiber, 2003; Vinal & Whitman, 1994; Wu & Connelly, 1992) and fit the profile of adult learners (Cangelosi, 2007; Miklancie & Davis, 2005; Seldomridge & DiBartolo, 2005; Vinal & Whitman, 1994).

These students held higher expectations of the academic experience, were intolerant of busy work, challenged faculty, and expected current teaching practices (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Miklancie & Davis, 2005; Vinal & Whitman, 1994). These students acknowledged the limits of their experience, and therefore felt a strong need for more clinical hours as well as more meaningful clinical experiences during their education (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Shiber, 2003). Student responses suggested that program pedagogies should acknowledge and incorporate the prior life and educational experiences of second degree students (Cangelosi, 2007; Shiber, 2003). The personal financial difficulties of full time study (American Association of Colleges of Nursing, 2005; Meyer, Hoover, & Maposa, 2005; Wassem & Scheil, 1994; Wu & Connelly, 1992) and the stress due to the time limitations and workload of an accelerated curriculum (Meyer, Hoover, & Maposa) were the main hardships reported. In response to a question about their preparation for the accelerated program, students listed their

prior experience in school (51.1%), motivation and maturity (20%), and time management skills (11.1%) as significant factors to meet the challenges of such a program (Wu & Connelly, 1992).

Research question

The overall goal of this interpretive phenomenological study was to articulate aspects of how students in an accelerated nursing program experientially take up the practice of nursing. Specific aims included: How do previous life experiences, education, and career choices influence the experience of second degree students? What is ambiguous and what is clear to accelerated nursing students within the clinical situation and how does that change over time? How do aspects of the situation impact students' performance?

Study Design

Sample

Following institutional approval, students from an accelerated master's entry program in nursing (MEPN) located within the western United States 19 students were purposively recruited for this study of how nursing students experientially learn to be nurses. Eligibility was limited to students in the first year of the master's entry program in nursing (MEPN) at the specified research site that were currently enrolled in a clinical practicum and agreed to participate in the study. Since more applicants were available than the target number desired, the investigator chose subjects based on achieving a maximum representation along gender, racial, and ethnic categories as well as background experiences of educational, employment, and other personal factors. Achieving diversity in the sample is not essential for an interpretive study, however it can

provide a broader range of standpoints from which a particular experience can be told (van Manen, 1990).

The sample included seventeen females and two males. Ethnicities represented included African American (1), Asian (5), Caucasian (11), mixed ancestry (1), and one respondent who declined to state. Participants ranged in age from 24 to 50, with an average age of 30. All held undergraduate degrees and three held graduate degrees as well. Majors studied included (but were not limited to) art history, biochemistry, international relations, literature, psychology, and sociology. Sample job experiences included actor, statistician, teacher, web producer/editor, paramedic, and chemist. Five had prior experience in health care and three had experience as a patient with a chronic or serious illness. The majority had volunteered in health or social service organizations.

Data collection

Audiotaped, semi-structured interviews with nursing students in the Master's Entry Nursing Program as well as participant observations of students in their clinical roles were the major data collection strategies. Interviews were conducted in a private setting at a time and place convenient to the participants.

During the first year of this study four students participated in individual interviews throughout the school year. Three of these students were interviewed on four occasions; the fourth person was interviewed only three times due to a difficult family circumstance. The following year 15 first year students were interviewed throughout the school year, initially in small group format, followed by two one-to-one interviews, and ending with another small group interview. This report interprets data through the third round of interviews with the second cohort of students.

Semi-structured interviews lasted from 60- 90 minutes and were conducted in a confidential setting. As much as possible during interviews students were asked to tell a story about their involvement in actual situations of care, beginning with their first encounters in the clinical setting. Stories of practical experiences at the patient's bedside allow the researcher access to the 'thrown' world of students. Benner, Hooper-Kyriakidis, and Stannard (1999) consider narratives as a particularly effective strategy to access the experiential learning of individuals in clinical settings since they give a sense of time, place, and characters within the story and capture what is important to the teller.

Data analysis

While aspects of the study, such as data collection and data analysis are described in separate sections of this article, it is important to emphasize that interpretive inquiry is iterative in nature so that procedures occur nonlinearly and at times simultaneously. For example, interview questions were guided by the practices and concerns of the students disclosed during the interview and thereby new lines of inquiry were opened within an interview and between subsequent interviews. Evaluation of interpretation occurred during interviews as the researcher verified her understanding of participant's statements by asking clarifying questions or paraphrasing the interviewers understanding in a questioning and clarifying manner.

Analysis began by reading through the entire interview, field notes, and other background information to get a sense of the whole. "The researcher begins with a vague and tentative notion of the meaning of the whole of the data and with the reflexive awareness that this notion is an anticipation of meaning" (Cohen, Kahn, & Steeves, 2000, p. 72). Field notes and notes from the participant observations were used as text in the

interpretive analysis and opened up a greater background understanding of the context of care. Interpretive notes were written during and after each reading of the narrative text.

Interpretation proceeded by moving back and forth between parts and whole as the whole was examined in light of what was understood from the evolving part and vice versa (Geertz, 1973/2000). Writing simple descriptions of what was happening pointed to the concerns and possibilities in the action as well as what seemed conspicuously missing or disturbing (Packer, 1989). Since exemplars and paradigm cases offer embodied examples of meanings embedded in a shared culture (Benner, 1985), this researcher aimed to articulate paradigm cases, exemplars, and thematic interpretation of the narratives to open up an understanding of the experiential learning of the student as lived within the concrete cases of the clinical environment.

Findings

A paradigm case: Betty's breakdown

This narrative illustrates the interactive and co-constitutive effects of a condensed and accelerated curriculum, the high stakes learning situations experienced by a group of bright, idealistic, and driven students, and the intrusive quality of everyday life concerns. In the student's own words, this narrative is about "the layering of everything else that's going on in your life" along with participation in an accelerated curriculum. The event occurred during the medical/surgical quarter that builds on skills learned in the first quarter of Fundamentals of Nursing. The students considered this the most intense and physically demanding quarter since each week included two full eight hour days of lecture, then two consecutive 12-hour clinical days as well as weekly pre-lab, intensive clinical preparation for the care of a specific patient, and periodic day long observations

in selected clinical settings. It was also the setting with the most acutely ill patients and during this time students were expected to learn to manage care on their own, as Betty related:

> I think yeah, the med-surg was the most demanding. I mean, forget the physical part of it, because I mean that doesn't bother me ever, but to integrate all the learning so quickly, and then to deal with an increasing level of acuity of patient. And then I have this totally distracting personal layer on top of it all, is you know, leading me close to a nervous breakdown.

The narrative continued with Betty recalling a phone call from the social worker at the SNF where she had recently placed her mother:

> We need to talk about moving her to the Alzheimer's unit, which I had just visited the day prior. Except she'd be in a bed, one of three in the room in the middle. And all I can envision is her crawling into bed with someone routinely at night. I mean, just none of these choices are great. And then I get distracted from the care, which already is really…fast pace…I'm a very intense person… And I take it really seriously, like we all should… I don't think I'm… unique in that way within the program, but I just vibrate like this from in there (she places her clenched fist to her chest and pounds it softly). And I think in retrospect, I think that I could never have foreseen the timing with my mom…coming right at this time of my life with this school and everything. If my mom wasn't part of it, I think I could easily focus and am driven, and all of that, but that layer on top you know, really is distracting…. And you know, dealing with people's lives and… there's very little room for making mistakes…I had a situation recently where,… my son was sick, my husband was traveling, I had to ask my father (who lives in another town) to take care of my son, because I had to go to clinical. I didn't want to miss…You can't recoup it. Once it's gone it's gone... And then of course you know I'm not going to be able to see my mom that entire week. So I am vibrating at just this crazy level. I get these intermittent calls from the home, and then I'm supposed to pre-lab now on two patients, two oncology patients…the level of acuity is definitely increasing, and the demands on us are increasing. And we're supposed to be handling two patients pretty autonomously at this point…quite frankly I could spend four hours pre-labbing on each patient. If I want to get into a level of detail which I actually find important… before you go in for the 12-hour day. .. I just need more time to kind of have it sink in, get my program down for the day. I really want to be solid with what I'm doing. Because I have to say at least me personally, I go in fairly unsure because of the lack of experience. .. I took care of a guy who had a bucal cell carcinoma who had had a flap from his forearm. Basically sewn, a free flap sewn into his cheek. Because they

had to remove his cheek and then use other tissue. And he was trached. Looked totally intimidating. And, I mean there's only so much I can pre-lab. And then the experience of doing a deep suction on a trach patient was like totally intimidating.
I: Had you done that before?
B: No!
I: So how did you go about that?
B: Well thankfully the nurse that I was working with stepped in and showed me how to do it, and I did a part of it. But… I did not feel comfortable at all. I'm practicing on this person…Who had half of his cheek cut out, and then the graft was from his forearm… And it's just intimidating… just looking at this person is totally intimidating. … But that particular week I had a sick daughter; I was not going to be able to see my mother who has no other visitors, and a traveling husband. And so it was just like loaded from the beginning. And then you know, two patients is kind of new to us this quarter, and I was just getting flustered… It was like impossible for me to take a step back and just say I'm going to do my best today, and if the urine doesn't get emptied on time it doesn't get measured it's not going to be the end of the world. You know, I just couldn't get myself to that rational place… And then I walked into the day, and the nurse I had been working with for two days prior, who's a fabulous nurse—Fabulous nurse, great teacher …Perfect nurse… I came in and one of the first things that she said to me was, "You know Betty, we have to look at your charting." And it was a totally benign comment, I think on any other day, but the tone that I heard was you know, you've been bad… it just like pushed me over…And unfortunately we didn't have the opportunity at that moment to talk, to review the charting, to get specific about what was going on. I mean it was like someone saying… I don't like you. And then walking away… Because in my mind I'm thinking, I'm working my butt off. I go in early, I spend a lot of time. I mean, I really prepare. And I take it really seriously. Not that everybody doesn't, but I mean I get there sometimes at like five in the morning to get a jump on things. I mean it's crazy. And so I get this comment and it just totally pushed me over the top… So, that I just… broke down… It just knocked my confidence to my knees…So I just started to get flustered and started to cry, and I couldn't keep it down. I tried. I tried kind of keep going with my day, because I'm thinking God I've got like you know, ten more hours. But I just felt like I couldn't focus enough in that moment to provide good sound patient care. I just couldn't do it… Because that, because like, and any other day it would have just been okay well can we talk about this at noon and get it over with. But this layer upon layer upon layer and then I had to take care of patients competently, and I just couldn't do it. ..So, well, but ultimately I left. I couldn't pull myself together. I was so at the risk of making mistakes, I just couldn't. I couldn't stop crying. I just couldn't; I could not pull myself together… And you know what? I did; I think I did the right thing. Because it was a patient safety issue at that point. I mean in hindsight, I should not have gone in that

> day. Too much personal stuff going on. It's too big of a job to be distracted like that. So I should have made that call rather than come on, you can do it. You know, you can do this. And, you know, I should say you know what, you can't. You're a human being and there's too much stuff going on…But any other day it probably wouldn't have affected me like it did. It was just that day in that moment.

Betty's family was a significant factor in the narrative. Her mother had recently been admitted to a skilled nursing facility, and Betty was the primary decision maker concerning her mother's care. Her son's illness and her husband's coincidental need for travel required Betty to enlist the aid of her father who lives in another town. Likely this arrangement was negotiated during the day prior to the first clinical day- during the time Betty would ordinarily focus on her pre-lab. It was clear that Betty is a driven, dedicated student who wants to enter the clinical day with the maximum preparation, before giving care to her patients as a novice. Within the pace of the accelerated program she understood the expectation to handle the care of two patients at this juncture in the program. As it happened one of her patients was a very visibly debilitated patient who required a high stakes procedure (maintaining a clear airway on a tracheostomy) that Betty had never performed before.

In the end, Betty's breakdown was precipitated by her perception of an ill-timed but corrective remark by a nurse whom Betty respected as a role model and teacher. Perhaps the nurse did not foresee the effect this would have on Betty. Stopped in her tracks Betty interpreted the remarks as a criticism of her whole person ("you've been bad", "I don't like you"). Yet ultimately this emotional response led Betty to realize that she was unable to provide safe patient care on that day, thus demonstrating her taking up of an ultimate good of nursing practice, safe patient care over her own learning and

performance agenda. She realized that she could not give safe care in her distressed emotional state.

Exemplars of student and world

Betty's story is presented as a paradigm case because of its power to illustrate the synergistic impact of the demands and stress of her family and the fast-paced, physical, high risk learning of nursing practice. As noted in the literature review and illuminated in the paradigm case, students attracted to accelerated programs are highly motivated and confident of their academic abilities yet feel less effective and assured in their abilities to perform clinically. The following exemplars further illuminate who these students are, as well as the context of care they experience as they take up the practice of nursing over time.

The Intense MEPN student. Most of the students used the term Type A to describe themselves as well as their fellow students. Their descriptions included: "very motivated and driven"; "bit of an all stars group"; "Intense, take themselves seriously"; "well cast, smart, and proactive"; "extremely academically demanding"; "a very driven, hard working group"; "very sure of themselves and outspoken". One student described the difficulty of being a type A personality in an accelerated program: The personality wants to do it all, "to read everything and live at the library." Another student described initially feeling uncomfortable and "blown away" by the intensity of the type A personalities and the level of stress and tension she perceived in her fellow students, even while admitting that she also considered herself "a type A". A few students who typified themselves as type A prior to entering the program were reconsidering the self descriptor in comparison to their fellow students whom they found far more intense than they would

characterize themselves. Another student commented favorably on the intelligence and shared goals and beliefs of her classmates. Further, she described her fellow students as "really type A, hardcore, and smart" and acknowledged that this added to the academic experience. Students were drawing on the literature about the highly achievement oriented, intense "Type A" personality identify by Friedman and Roseman (1974) as being "coronary prone." It became an apt quick phrase for MEPN students to describe themselves and their classmates.

However, the fact that students "take themselves too seriously" made it hard to be around them all the time. As another student described the group, "I think all the MEPNs in the program are overachievers, and…I think it's a blessing and it's a curse." Another student described how students' individual anticipation and excitement heightened the atmosphere of expectation and stress. They paid attention to their classmate's sense of transitions in their identity and accomplishments as well as their own:

> And the second thing is the sheer enthusiasm of like all our classmates, kind of just multiplied… I mean everyone is feeling pressure. Everyone is trying to prove to themselves that they can do this. Everyone's making identity shifts. I mean most people are coming from a different identity. And so we're all in this. And then when it all comes together, it's just like a storm of emotion and expectations. So… the energy kind of feeds off each other.

Students formed an intense but extremely useful learning community. The "blessing" of being within this learning community quickly became evident during the group interviews. After the initial interview question was framed, students typically would articulate answers in a dialogical format, frequently adding to the comments of the other student with little need for the interviewer to intercede. Within this community of learners, no students were left to feel that the issues they were dealing with were private. They sensed the ways in which the transformations in themselves and their classmates

were both personal and social as they shared and negotiated meanings of their practical experience in the clinical setting (Lave & Wenger, 2006).

Entering a foreign world. Upon entering the clinical world the student was overwhelmed by the unfamiliarity of the environment. Students in accelerated programs often enter the clinical floor during the first or second week of their schooling. Students described this as being "plunged right in" or "hitting the ground running", or "being put out on our own". There were no maps or operating instructions to help the students find their way and create order from chaos in order to function ("I'm one of those people that likes to read all the instructions on the back of something before I use it"). There was no sense of context or grounding, no prior experience with which to confront and cope with acutely ill people using oddly foreign social conventions as noted in this student narrative:

> The hospital is like a totally foreign country; it's like a foreign plane. Time is totally different, it's constantly this weird light; there's no natural light going on, and it's all these weird noises and beeps that you don't understand. And then there's like the language. The nurses-- I didn't understand probably three –quarters of the conversations going on in the halls, between doctors, between doctors and nurses, and the pharmacists and the unit secretary. ..then you try and read a chart the first couple days. You have no clue what any of it says because you don't understand any of the acronyms or any of the meaning behind. It's a totally foreign language and it really reminded me of the times that I've traveled to foreign countries and just ultimate culture shock of what's going on, where am I, how do I even, what are the right behaviors in this environment? Just everything's so different…—I mean, this was one of the funniest things too—realizing that the very first time you meet somebody you ask them how their bowel movements were. And, I'm sorry; I have never just met somebody for the very first time and asked them the last time they had a bowel movement. And that was just so strange to me.

Everything was unfamiliar: smells, sights, sounds, and even time. Light was unnatural and constant, and there were unknown beeps. The language was only vaguely familiar,

with the use of acronyms peppered into most conversations. It was akin to being in a foreign land where even the customs are remarkable, as for example, meeting someone for the first time and asking about typically private bodily functions. The clinical world is foreign for any novice student, however they encounter "natives" and it is difficult even for instructors to remember just how foreign this environment is for the entering lay person.

Novice again in a new world. These novice students' response to the newness of the clinical world is heightened perhaps by their prior sense of being at home in a familiar work environment. In their first clinical experience they encounter just how much of a novice they are and how much they have to learn. The strangeness of the new world was "nerve-wracking" and even for students with prior volunteer experience in the hospital their presence in the hospital this time held a new significance since "this was the first time where it was actually going to serve some sort of purpose." Many students entered the clinical world with little expectation, a certain amount of naiveté. With little sense of *typical*, nothing was expected and everything was a surprise:

> But, you know, I think the first day wasn't even that hard, because no one expects very much of you the first day… I remember initially feeling excited and nervous, but it took a few weeks to realize how little I knew. And that's when I really started getting nervous about it." [Nothing seemed planned or ordinary.] "I've never seen gunshot wound before, let me look at that. Or, that's the color of urine coming out of a—I mean everything is new…it's hard to, you don't have anything else to base it on so there's nothing that's old news.

A student compared the clinical learning to "almost having a job" that included a practical side of learning important but mundane knowledge such as the operation and significance of the call light: "knowing where the call light button was. I didn't know that for a few weeks. It was like no one had pointed out to me… it just magically

appeared and would blink and I didn't know where it came from, you know? And how you turn it off." Students felt clumsy, slow, and inefficient ("bogged down in those little nuances") in comparison to the observed actions of the nurses on the floor who "do everything so seemingly flawlessly, efficiently, with grace." Not knowing the very basic skills made students "stick out like a sore thumb" ("People would laugh, but there's a right way and a wrong way in nursing to do these things and it was a self-conscious experience"). More significantly, all of these background details confused and obfuscated the student's attempts to gain a sense of salience: "obviously you can learn how to work the phone and silly things like that…and that shouldn't be given the same priority as doing an accurate manual blood pressure or something like that. But this just adds to the not knowing."

Not knowing the mundane made navigation in the new environment difficult and created social embarrassment for the students. This seems like an easy problem to fix with skills labs focused on the everyday and mundane, billed in just such a manner, so that the students are clear that these aspects of clinical are not difficult, nor even the focus of their clinical learning. They are provided primarily to smoothe the student's practical and social transition to the clinical environment. Because these students are so bright and advanced academically, it is a challenge to teach these mundane aspects of nursing work without making them either a hurdle to the student's orientation on the clinical, or introducing them as a major or significant aspect of nurses work. These are orienting aspects that need to be put in the background for more significant clinical learning as soon as possible.

The *physical demands of nursing work*. A rarely articulated part of taking up the practice of nursing is the demanding schedules of hospital shift work, and the physical demands of positioning patients, getting them out of bed et cetera. Not only did students complain about the physical demands of 12 hours on their feet but also about the need to wake up before dawn to commute for an hour and arrive on time for a shift report. It was a challenge to develop a rhythm of waking and sleeping to accommodate the early start time of hospital shifts. This altered schedule was more difficult to accommodate when a student was anxious about confronting the new clinical world:

> In the summer quarter, and even this quarter, one of the hardest things was being able to go to sleep at night—have a good sleep and wake up ready to go. And I remember just going to bed with lots of anxiety, thinking that I wouldn't be able to fall asleep because you have to go to bed at ten p.m. And then waking up and then doing the same, and then coming home and not having any time to do anything but eat dinner and then go back to bed. So that was surprising. I didn't think… managing sleep would be such a problem.

In addition to learning a new work world, the students had to learn new time patterns, and new physical demands.

The pace of learning for clinical assignments The intensive clinicals were physically and emotionally tiring so that students had less stamina to confront the intensive reading and other aspects of their coursework. The students experienced a pace in which every minute felt crammed with activity. Every day was at an accelerated pace, the tone of the day felt very "occupied" and students said, "it is doing things I've never done before". The concentrated nature of an intensive program ("you're really basically working a full-time job with your classes and clinical instruction") as well as large amounts of dense "clinical textbook reading" created pressure in the driven students ("it's kind of hard to let go of, not being able to read everything all the time"). One

student suggested being in an accelerated program was "the microwave version" of learning nursing as compared to the "slow-baked kind" in a four year traditional baccalaureate curriculum. As one student remarked about the fast-paced momentum, "Your program is so accelerated that it's like you don't have time for missteps." Students acknowledged they entered the program fully aware of the potential for intense stress. "I signed up for intensity, and powering through a lot of material and a lot of learning in a small amount of time…but it's still stressful."

Sleep, exercise, eating well, and "balancing" the rest of their lives with the demands of the program often emerged as key to tolerating the rigors and stress of an accelerated program. One student felt the program administrators relayed a message "that our personal lives and some sort of balance isn't important…figure out how much your family needs and how much time you're going to have with them and then expect to spend less than half of that." Another student claimed that if she wasn't exercising, eating and sleeping well, then "the emotion of it can really take over …you really have to take care of yourself to stay on an even keel." It is unfortunate that part of this hidden curriculum was that family care, personal health, exercise, sleep and rest were not endorsed by some faculty since this hidden curriculum message conflicts with their overt teaching about the importance of a balanced life for health promotion and illness prevention in their courses.

What is at stake. Students were well aware, for some even before they started nursing school, of the implications of their actions as nursing students. People's lives were in their hands:

> So to start taking your own patients, I was personally afraid that I was going to make a mistake or do something that would be terrible. I mean it's very

> scary--I knew this coming into nursing school. I knew that you're responsible for possibly somebody's life. And you could make an error that will--it's not like you forget to mail something and sure that could be terrible and maybe you'll lose your job, but you could overdose and you could kill somebody!

Nursing also includes attention to details that matter to someone's well-being compared to past errors of forgetting to mail an important letter. One student noted that this attention to detail needs to be sustained throughout the work day that gives the student a sense of continual hyper-vigilance so that nothing is missed ("nursing is incredibly detail-oriented, and it seems like, you have to maintain a high level of being detail-oriented all day long consistently. And I think it's really draining"). Even as early as the first day of clinical and orientation students were confronted with the possibilities and what is at stake; this was a profoundly new experience:

> It was terrifying. I remember being absolutely scared and uncomfortable. I'd never been around acutely ill people ever. I had no context to even to begin to understand At the first orientation they show you where the crash cart, the code blue cart is, and you're just so hyped up into this [possibility}'anything could happen at any moment, and what would you do?' The hospital gives you the policies and the procedures and if anyone did code, you would be expected to start CPR-- And I remember the first couple weeks being asked to feed patients, and what a scary, terrifying thing it was to be asked to feed a patient who has a risk for aspiration and you have to make sure they're sitting up totally upright and they're chewing all their food and they're swallowing. Something that you would think would not be scary… I was scared people were going to die, I guess. And in some way we'd be responsible or in some way we would hurt rather than help.

Swept up in strangeness the student felt terrified because the possible dangers for her patients felt real but undefined. There seemed to be few touchstones on which to build understanding. Almost immediately the student was confronted with the hospital reminder of the reality of death: the code blue cart. In truth, "anything can happen at any moment" and even the student would be expected to respond in some way to help save a

life by starting CPR. The once benign act of helping to feed a patient became "scary and terrifying" when the student was made aware of the dangers and consequences of aspiration for certain patients. There was an overwhelming sensitivity to the notion that rather than helping a patient the student could unwittingly harm someone. Yet students felt that this sense of responsibility was actually a necessary context in a high stakes learning environment, because it set the goals for clinical learning and the nascent sense of accountability and responsibility of the nurse. The risks were real, and it was better to know them than ignore them.

Students sensed the vulnerability of patients, patients who were sometimes at the very beginning or near the end of their lives, or in debilitated and suffering states. And while patients were in these vulnerable states, fledgling medical personnel were going to practice on them, perform skills that the students may have never done before as in this student's observation of a respiratory therapist in training:

> There is a level of danger of just nursing school, or training people in medical school. Like I'm "Oh, my God. Are you kidding me? This person is going to do this procedure and they never have before? Who wants to be the one who gets that procedure the first time? Not me, thank you. That sucks that there is somebody that's the first time and hopefully it goes okay for them. I was with this guy yesterday who was just doing arterial blood gases and he's like "If I get one out of four that's not bad."

The novice as a lay person appropriately identifies more with the patient than with the learner. The challenge in professional education is to maintain this patient-centered focus throughout the educational program. It wasn't only nursing students that were involved in high stakes situations. In this situation the student was talking about a novice respiratory therapist drawing blood gases in an intensive care unit, and as the student concluded, "okay, with blood gases that's not that big of a deal except for what if that guy really has

something going on and we need to find the results quickly and the delay if you get venous blood instead of arterial blood and you're delaying us finding out, there are implications to everything." Students, even respiratory students, needed to have an ethical escape clause for their learning. Sometimes the timing was just too crucial and their learning had to be deferred for the sake of the patient. Student participants seldom spoke of using their clinical instructor as a safety net although they were often caring for acutely ill patients. The students relied on the nurse they were paired with yet the students were reticent to involve the nurse as a consultant, and instead took a posture of hyper-responsibility.

Discussion and Implications

Accelerated students as novice again

Accelerated students are often graduates of demanding undergraduate programs and many have come from graduate programs and/or professional careers. MEPN students experience feeling novice again. After being out in the world as successful individuals they are once again thrown into a world with little background understanding to ground them. It is painful to no longer be self assured and competent, to no longer be the authoritative voice that other people turn to. They claim to be excited when a lecture topic brushes against an area of knowledge where they feel some comfort or perhaps even expertise ("You know, you try to cling on to those little bits of you know, knowledge that you had"). Tacitly, the second degree students know what it feels like to be competent in a field, due to their prior experiences in academia and the job market. Now they are more keenly aware than the first career generic student of no longer being competent, of feeling a loss in confidence and ability. Some of their prior job skills will no longer fit

their new job context and this may not be immediately apparent to the student. They come with both explicit and tacit expectations about their job performance capabilities and these expectations are quickly challenged and unraveled.

Perhaps more significantly, their former academic and career pursuits appeared structured, ordered, and predictable compared to the seemingly chaotic, high knowledge-skill, yet underdetermined relational world of nursing. These students entered the accelerated nursing program with a drive towards perfection, and with some expectation that this accelerated program would mirror their former academic experiences. Students with prior experience of successful career trajectories and academic success may be more optimally positioned for certain aspects of an accelerated program (academic learning, critical thinking and the ability to synthesize knowledge, and perhaps aspects of the ability to *be with* people). Yet coming from a more circumscribed world there are aspects of their prior being-in-the-world that might hamper them in embracing an underdetermined practice such as nursing

Experiential learning

A practice, such as nursing is a cluster of patterned and interrelated ways of being that relies on socially embedded practical knowledge (Dunne, 1997). There is no discrete set of content that stands alone and apart from the practice setting. Nursing practice demands situated cognition (Lave and Wenger, 2006). For example, as noted in the students' accounts, from their very first encounters in the clinical setting they have some understanding of "what is at stake" and what matters to patients and providers within the clinical environment. Their concerns for patients' vulnerability, safety, and well being are beginning to organize their actions and newly learned ways of being with patients.

According to Benner (1997), care ethics are embedded within the social community of nursing practice. Care ethics are based in particular communal notions of the good and are attentive to the needs, desires, and possibilities of the parties involved, in particular the patient and family members. Benner, Tanner, and Chesla (1996) describe the notion of the good as a kind of everyday ethics in which the nurse engages each time she encounters a patient. It is based on the usual code of ethics yet goes beyond a rights or procedural notion of ethics by considering the good to be actualized in the situation. Each decision that is made based upon the clinician's notion of the 'good' in the particular situation that leads to the decision for the patient. It requires a particular contextual situation since it is based on 'noticing and attending' what is important to the patient and family in particular situations (Benner, Tanner, & Chesla, 1996). In this way, experiential learning forms and re-forms the students' skills, knowledge use, concerns, and actions through concrete experiences.

For the nursing students, such learning is transformative, in that new understandings or skills literally change the individuals' embodied ways of perceiving and orienting to the situation (Benner, Sutphen, Leonard-Kahn, & Day, In progress). Learning shifts from a focus on the individual to participation within a social world (Lave & Wenger, 2006). For nursing students, world-transforming identity changes as well as taking up practical skills and knowledge occur by engagement within the everyday world of a community of practice and in encountering and caring for patients and families. The new skills and capacities, and new member-participant status in a practice all contribute to the student nurse's formation of a new identity.

Guides and framings provided by clinical faculty

Nursing faculty can guide students to develop an anticipatory set to deal with uncertainty, especially useful for people coming from success and competence in a more circumscribed world. For example, when students enter the clinical world it requires that they change the boundaries of their social access (Benner, Hooper-Kyriakidis, & Stannard, 1999; Benner, Sutphen, Leonard-Kahn, & Day, In progress) as the skills of involvement with patients are concerned with completely new social and emotional boundaries and concerns, as with the student that stated: "I'm sorry; I have never just met somebody for the very first time and asked them the last time they had a bowel movement." Early in their clinical practice students may not yet understand the implications and significance of personal questions about bodily functions. In addition, students may not yet feel the sanction of the role sufficiently to feel comfortable in asking questions about what would have always been experienced as private bodily functions and personal space, and thus off limits to a stranger, in all their former life experiences. Teachers can articulate the skill and significance of addressing intimate questions that adds to the understanding of both the generic and second degree students. Having students rehearse with each other could help diminish some of the strangeness and clarify the relevance of the questions. In this way, the clinical faculty are like cultural anthropologists, skillful at describing the coping demands and strangeness of language and rituals of the new culture in the context of the lay understanding or foreigner's social access to that world.

Initially, new students' secondary ignorance (they don't know what they don't know) and limited expectations by others protects students from some anxiety. As

expectations and assessment responsibilities increase, so can anxiety about "missing something" due to the lack of comparisons from other similar situations. It is important for students to track their observations and comparisons as they evolve in their clinical assignments in order to build on their experiential comparisons. One student used a journal to track her understandings and misunderstandings:

> I started keeping a log… things that I missed or lessons I learned during that day. Or things I missed that I shouldn't have missed, or things that I caught and that I was proud of myself for catching. And I just kept a log, a journal.

The range and sheer number of "small" things to learn can be disorienting and increase the student's vigilance about everything, even though they readily recognize that some things are more important than others. Time in the skills lab orienting to hospital beds, call lights and even phone systems can take some of this pressure off for the students. The lack of orientation to these small things underscores their taken-for-grantedness. Learning these tasks can be framed in such a way that the student can see that while mundane, these relatively simple tasks are part of a necessary skill set to navigate more smoothly within the clinical environment. The learning goal is to avoid having the student feel insulted or their intelligence demeaned by these simple, yet major entrée skills required to navigate the clinical environment smoothly.

Learning to read a chart is a layered and dense task that needs to begin prior to entering the clinical unit, and then revisited as required to assess patients in relation to their past clinical status. In this way, the student is introduced to charting before meeting the particulars of the patient encounter.

Conclusion

Clinical learning situations often involve “a level of danger” in “dealing with people’s lives” where “there’s very little room for mistakes.” While the concentrated, fast-paced nature of accelerated programs and the potential intrusion of everyday life concerns are unavoidable, there are guides and framings that faculty can provide to enable the initial passage of students into the clinical world as well as to help the student navigate the continually uncertain terrain of experiential learning. Clinical concrete cases are always more complex, uncertain, and ambiguous than can be captured in theory, although theory can act as a guide, especially for the novice. For example, in Betty’s paradigm case there were theoretical bases for performing the deep suctioning of the patient’s tracheostomy to provide a clear airway. However, not only had Betty not performed this skill on a live patient, the difference in his anatomy, due to the free flap of former forearm tissue sewn into his cheek, made the particulars of the clinical situation intimidating. In this case it was a necessity for the nurse to step in to provide the care and act as a guide for Betty. As apparent in this case, knowledge gained through experience broadens, extends, and refines existing knowledge and allows the fledgling practitioner to begin to recognize what is important in situations and compare situational similarities with prior experiences.

CHAPTER SIX

Developing a sense of agency and responsibility through caring for patients

Background

Fewer people are entering nursing in their early and mid-twenties as was the trend in earlier decades, however this trend has been offset by large numbers of people entering the profession in their late twenties and early thirties (Auerbach, Buerhaus, & Staiger, 2007). One of the most active groups of recruits to nursing schools have been older students who already hold baccalaureate or higher degrees in a field other than nursing (American Association of Colleges of Nursing, 2005). Nursing schools that have started Master's entry programs or second baccalaureate degree programs have found large applicant pools, consisting of second degree students who want to make a career change, often from sciences to a more people oriented career.

As of 2007 there were 205 accelerated baccalaureate programs and 56 accelerated master's entry programs in the United States (American Association of Colleges of Nursing, 2007). In the typical master's entry program the student is eligible to take the NCLEX exam after approximately a year of schooling, and then may elect to continue on towards an advanced practice degree. While the literature captures demographic information about this new student population there has been little research thus far on how these students take up the practice of nursing and no published research on the experience of students specifically within a master's entry program. In particular, what clinical experiences stand out for students as formative in their development as nurses?

Literature review

Second degree students attracted to accelerated programs tend to be highly motivated (Kohn & Truglio-Londrigan, 2007; Meyer, Hoover, & Maposa, 2005; Miklancie & Davis, 2005; Vinal & Whitman, 1994; Walker et al., 2007), perform at least as well as traditional students on academic measures (Seldomridge & DiBartolo, 2005; Shiber, 2003), and have higher expectations of their academic experience (American Association of Colleges of Nursing, 2005; Cangelosi & Whitt, 2005; Miklancie & Davis, 2005; Vinal & Whitman, 1994; Walker et al., 2007). Their prior life experiences and previous academic successes are regarded as significant in positioning them towards success in a fast paced and intense program of study (American Association of Colleges of Nursing, 2005; Cangelosi & Whitt, 2005; Miklancie & Davis, 2005; Vinal & Whitman, 1994; Wu & Connelly, 1992). However, these students acknowledge the limits of their experience and feel a strong need for more clinical hours as well as more meaningful clinical experiences during their education (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Miklancie & Davis, 2005; Vinal & Whitman, 1994).

Two studies were found of accelerated students' experiences in a BSN program. Cangelosi (2007) interviewed nineteen former students from six different nursing programs in the mid-Atlantic region of the United States. The group was asked to reflect in advance on the question: "Is there an incident that stands out in your mind that best prepared you for your current clinical position?" Using a hermeneutic phenomenological approach, the researcher explicated students' concerns for more focused and individualized clinical teaching approaches that built on their prior life experiences.

Students suggested a reduction in procedural learning, busy work, and sacred cows; for example eliminating the demand that all skills needed to be done in a lab setting before they were done in the clinical setting. The students expressed confidence in their academic abilities but felt more inadequate clinically and therefore desired more clinical experience and more effective clinical teaching approaches.

The lived experience of *being* second career baccalaureate students was interpreted in a study by Kohn and Truglio-Londrigan (2007). Using hermeneutic phenomenological methods the researchers interpreted interviews by five participants over the three semester course of their study. Themes articulated the students' entry into the program and described their transitions from their former lives into an intense and stressful place of feeling novice again. Students also shared their perceptions of a lack of faculty support as well as students' desire for more input into curriculum changes that affected their experience. Though this is a single study with a small sample size it proposes some interesting lines of inquiry about the situated transitions and emotions of the students as they prepared for and then took up the practice of nursing. These students' responses are probably realistic given the cognitive, clinical practice and ethical challenges of nursing practice but they are probably also a result of a lack of re-design of nursing educational programs to fit the special needs of second degree students. Few programs have developed specially designed courses for second degree program students. Because of stringent educational budgets, most schools of nursing have tried to use pre-existing courses to fit the second degree students and have blended their undergraduate and second degree students.

Due to the limited studies of the clinical experiences of students in accelerated programs this researcher reviewed qualitative studies of generic undergraduate nursing students within the clinical environment to uncover aspects of the complex phenomenon of taking up the practice of nursing. Several significant themes were evident across the studies. One such theme was the interrelatedness and reciprocity of confidence and the increase in competence as one developed skills (Garrett, 2005; Haffer & Raingruber, 1998; M. Kosowski & Roberts, 2003; Stockhausen, 2005; White, 2003). A lack of confidence in skills tended to cause preoccupation with performance and the possibility of making an error while proficiency and competence in the doing of skills freed the student to then focus on the patient.

Another theme was the unanticipated emotional impact of taking up the practice of caring for the sick (Beck, 1993, , 1997; Cooper, Taft, & Thelan, 2005; Neill et al., 1998; Sedlak, 1997). Students often felt overwhelmed by their exposure to human suffering (Eifried, 2003). A related theme was the overwhelming sense of what is at stake in caring for the sick and vulnerable (Baxter & Rideout, 2006; Beck, 1993; Cooper, Taft, & Thelan, 2005; Haffer & Raingruber, 1998; Neill et al., 1998; Sedlak, 1997). Confronted with their own lack of agency due to their lack of knowledge and skill, students felt anxious and fearful of making errors and harming patients as they found themselves in situations of uncertainty with little if any background skills and knowledge to guide their doing. This is a common finding among undergraduate students (Benner, Sutphen, Leonard-Kahn, & Day, In progress; Rodriguez, 2007)

Connecting with the patient meant being open to understand what mattered to the patient (Cooper, Taft, & Thelan, 2005; Ironside, Diekelmann, & Hirschmann, 2005a, ,

2005b; M. M. R. Kosowski, 1995; Sedlak, 1997; Stockhausen, 2005; White, 2003). Ways of connecting with the patient included envisioning possibilities for the patient (Eifried, 2003; Ironside, Diekelmann, & Hirschmann, 2005a; M. M. R. Kosowski, 1995), seeing the patient's and family's perspective (Cooper, Taft, & Thelan, 2005), learning the humility of caring and being with the patient (Stockhausen, 2005), and connecting the patient's past, present, and future (White, 2003). Each of these studies adds to our understanding of the patient's possibilities and concerns.

The limited studies of second degree students in accelerated programs suggest that these students may experience their entry into and subsequent day to day clinical experiences differently than traditional baccalaureate entry students. How do their previous life experiences, education, and career choices influence the experience of second degree students? As noted, there are only two studies of the potential effects on learning of condensing and accelerating the curriculum, as is requisite in second degree programs. Accelerated nursing programs, and in particular master's entry into nursing programs, tap into a new and highly talented student population, yet schools have not tailored their curricula to meet the needs of this richly experienced group.

Study Design

Using interpretive phenomenology, this researcher sought to articulate the background understanding of how MEPN students experientially take up the practice of nursing within the clinical setting. A specific aim that is articulated in this article is: What pivotal formative experiences do students identify as helping them develop and differentiate their clinical practice and thus, form their identity skilled know-how as a nurse? Phenomenology as method strives to uncover the taken-for-granted and tacit meanings behind skills and practices and their interconnectedness within the practice of

nursing and the taking up of that practice. In addition, phenomenological research into the lived experience of second degree students can build on the reviewed studies of undergraduate students and uncover more of the background understandings that ground the taking up of the practice of nursing exploring the possible differences that may exist between students with different educational and experience levels.

Sample

Following institutional human subjects research approval, students from a master's entry program in nursing (MEPN) located in the western region of the U.S. were purposively recruited for this study. Eligibility was limited to students in the first year of the program, were currently enrolled in a clinical practicum, and agreed to participate in the study.

Data collection

Four semi-structured interviews were scheduled with each participant throughout the first year of study (N=19). Fifteen students participated in alternating small group and individual semi-structured interviews (two small group interview and two individual interviews); four additional students participated in four individual interviews. Due to declines to be interviewed based on personal circumstances, three of the participants were only interviewed on three occasions. Field observations of a subset of students engaged in the care of patients provided an additional source of data since their narrative accounts within the interview setting could preclude taken for granted details within the situation of care (Benner, Tanner, & Chesla, 1996). This research report is based on the first three interviews since the last interviews were in progress during the interpretation.

As much as possible during interviews students were asked to tell a story about their involvement in actual situations of care. Narratives give the researcher access to particulars and direct us to what matters to the informant (Benner, Tanner, & Chesla, 1996). Stories present how the person perceived actual situations and the story tellers concerns organize the story and reveal how individuals perceive and understand their worlds. By thematic interpretation of the narratives one can understand the 'lived' experiential learning of the student within the clinical environment and thus gain more knowledge about the culture of nursing students. During the first interviews this researcher noted that when students were asked to recount the story of a particularly pivotal clinical experience the student would often relate a story of being responsible for the independent care of a patient. In subsequent interviews students were asked to describe more about these experiences and why they considered these pivotal events.

Data Analysis

Narratives describing their independent care of patients were identified and interpreted, specifically to articulate the concerns of the students within their involvements with patients. In the same manner that shared social meanings allow us to understand the flow of a conversation, in interpreting narrative texts "we recognize the kind of situation people are acting in and the concerns and involvements their activities embody" (Packer, 1989, p. 111). Subsequent thematic analysis interpreted the common threads of meaning, comparing the literal meanings of the participant's words to developing themes, as influenced by my changing understandings (forestructure). Exemplars were used to illustrate qualitative distinctions both within and between themes

and as noted by Benner (1994) are useful as strategies for explicating shared meanings within the culture.

Findings

Developing clinical responsibility

For each of the student participants independently caring for patients meant taking on ownership and responsibility for someone's well-being. This sense of being in charge of the patient's safety and well-being heightens the student's vigilance. Emotions such as fear and concern enter the picture as the student acknowledges, "Am I going to be able to do this?" Independent care of a patient projects the student towards the possibility of being a nurse. The student's perceptions are altered as she or he focuses on aspects of the situation. In the following exemplar, being in charge of the patient's care solicits the student, Anna, to pay attention to equipment and the particular details of care:

> Yeah, I think naturally there's something when you're responsible for that patient, I think you just act completely differently, you know? You ask more questions, you have to think through what's wrong with them and what could go wrong with them. You just even walk into the room and see things completely differently. I know I do. If I'm just observing I may not pay attention to how many lines they have or what's running or how many liters of oxygen… they're hooked up to. But if I'm actually trying to take that patient on, I'd better stop and look at every single detail, because I actually *have to be responsible. I know it*…I think…observation is beneficial; I really prefer to see someone do something first before I do it. But as a learning experience, it's much better… to be the person who has to do it. Now the corollary of that I guess is that… it's riskier for patients… when we're actually the ones responsible it means we can miss things. But I think it, you just learn…more**…** it's one thing to see it but eventually after one time you have to do it yourself.

Anna understood there was an element of risk to patient's safety within her experiential learning. However, the feeling of accountability motivated Anna to view the situation

differently, even while acknowledging that the nurse she was working with was ultimately responsible for the patient's well-being:

> Yeah, I have a real different approach if I know someone else is- the buck stops with them and not with me. I don't know if everyone's that way, but it's totally different for me. Meaning that… I'm responsible for catching something. And I'm responsible for making sure things are going well…I mean of course there are nurses that are observing…and really the buck kind of stops with them. But I do try to take it on as my personal responsibility. Yeah, I think so…I take it very seriously… And… without that seriousness I don't think I learn as well, so…Yeah, you know**?** Without the gravity for me- Without feeling like the patient's health is a little dependent on me, I just don't learn as much. I think I need to feel that what I'm doing is making a difference, and I just take it more seriously. It's also why I wake up in the middle of the night concerned about something that I forgot. You know, I find it to be very anxiety-provoking, but I don't think I could be a nurse if I just observed patients. Like if that was my whole clinical experience, I wouldn't know what to do.

When a student takes up the responsibility for the patient this means taking up the emotions of concern and vigilance. The involvement and sense of agency and responsibility in the situation allows the student to feel the pull of different risks and possibilities within the situation. It means that the student has taken up a concern for what ultimately happens for the patient. Somehow before that the student might imagine that "I'm not going to really make that much of a difference in this patient." The sense of responsibility or commitment becomes a motivating force. Personal ownership or commitment invokes a sense of responsibility and pulls for ethical comportment within the situation.

Developing their own habits and styles of practice

Becoming at home in a social and physical environment entails using equipment flexibly, navigating the physical environment, dealing with social expectations smoothly and skillfully, and developing one's own care routines. Students acknowledged that

managing care on their own allowed them to develop their own style of care. Nancy stated: "I control what I do for people, and [I'm] not shadowing the nurse anymore, and not doing it her way anymore. I can do it my way." In a similar vein Mary described the motivating force of independence: "being able to take my own initiative and have my own way of doing things." Having a sense of control allowed the student to take initiative and develop a personal strategy for handling the care of the patient. In addition, from within care the student was able to improvise towards better organization, as Freda noted:

> Oh I think it's extremely important because everyone has their own flow. I think the only reason for me that it's important to shadow a nurse is to see how people do things and to draw on their ideas and what works for you and draw on their knowledge. But I think managing your own patient aids you in developing. Because you're eventually going to develop your own way of doing things, and being able to do it in practice and kind of refining it as you go before you're actually thrown into the wolves and actually managing four or five patients on your own is a good thing to just get your own flow and your own strategy and your own plan going. So really important, really, really important.

Freda emphasized the importance of developing one's style in managing care skillfully, while drawing on the skills and knowledge of experienced nurses that she observed. Freda's description points to the embodied development ("being able to do it in practice and kind of refining it as you go") of the individual nurse's clinical imagination, and ongoing organization of a complex yet open-ended practice. This demonstrates a movement from imagining and performing skills as singular task or elements of care into an orchestrated, sequenced whole that works and makes sense to the individual nurse. Such embodied skilled know how is at the heart of clinical learning in a complex practice such as nursing.

Taking up and feeling the authority and responsibility of care interventions

At first the novice students felt like guests wearing costumes. They were dressed as designated nurses, but did not yet have the knowledge or confidence to feel they were entitled or capable to give directions to patients, or that patients would believe in them sufficiently to follow those directions. In the following account Nancy described how she perceived a change in her relationship to the patient when she was caring for the patient on her own; the student had gained legitimacy through her experience, and increasing knowledge and capacities. The student had reason to be with the patient other than "idle chatter". She no longer felt like a "guest" who was intruding on the patient or making illegitimate claims or requests from another person:

> I'm not intruding, or I'm not, oh my God maybe you didn't want to talk to me; maybe I shouldn't bother them. But you know, they're my patient, I have to take care of them; I've got to go in and ask this and I don't care if they're ready to do this or not. Like, we have to do this because it's for them. I don't know. I learned how to be a little more confident and not just—not like I'm bothering them but I'm doing this for them, you know?

Often students felt insecure in their new found skills and hesitant to approach the patient in an authoritative manner. They had to gradually take up and feel both the entitlement and responsibility to coach and instruct patients, or even perform uncomfortable procedures. Sometimes these responsibilities for care, such as turning the patient, dressing wounds, or getting the patient out of bed are unwanted by the patient in discomfort. Students had to learn to feel the significance of taking up their legitimate responsibilities and roles as a nurse. When "charged" with the care of a patient the student was gently pushed towards a more authoritative stance by the need towards action aided by their clinical instructors, their theoretical knowledge, and by the patient's needs. For example, they now had a better grasp of the hazards of immobility, and felt more

entitled to assertively prevent the hazards of bedrest such as deep venous thrombosis, stasis pneumonia and so on. Once they had a grasp of the dangers of immobility, the student felt entitled and empowered in the role of nurse to prompt the patient to turn, move, and ambulate for the patient's own well-being, even when the patient didn't want to. Nancy demonstrated this desire to enact a patient need:

> Let's say I'm afraid to walk into the room- I don't want to go in right now because I'm kind of scared. I'll just tell my nurse, right? Like hey, is it okay if you come in with me, or you know, he really needs this right now. Can we check on it together? And then there's always a reason for me to not have to take the initiative and do it. And when I am on my own, I don't have a nurse I can follow…So I have to go in, suck it up and just go in, you know?

If the student had entered the room with the nurse the authority for care would have shifted in weight from the student to the nurse. While managing care on her own the student didn't "have a nurse to follow". In addition there was a shift motivated by the direct connection with the patient without the middle person of the staff nurse (as arbiter) to interpret what is needed to care for the patient. Feeling the weight was formative for the student, moving her from acting like a nurse to being the responsible nurse in the situation. The student, Diane, received direction for action from the patient in the following situation and bypassed the filter of the nurse's judgment:

> I feel more confident and independent. I can do more stuff and I'm making decisions more now, coming to conclusions about patient care, taking information that I'm receiving from the patient as to what they need or how they're doing and turning that into action. Whereas before I think I'd take information and then run to my nurse or my instructor and then have them turn that into action.

Sometimes there were aspects of care that the student felt less confident about, and therefore sought out a nurse to give more background information before the student felt comfortable to perform the skill. In this way the student was

building a repertoire of situations in which she could independently clinically reason:

> Sometimes it's like that. Sometimes it's a situation where something happens and I think okay, in this situation, this is what needs to be done. But I don't necessarily act on it because I'm not totally confident. It's what I think is right. And then if I go and have it affirmed, then I think to myself okay, so that's right. And then next time it happens I won't need that affirmation, so it's like building a repertoire of pre-affirmed things that I can do on my own afterwards. And sometimes it's you know, coming into my own and thinking okay, that's right. Here's what I'm going to do.

In this situation Diane was fairly certain of what needed to be done yet felt enough uncertainty that she still wanted to have her judgment affirmed by a nurse**.** Agency, i.e. the ability to take a stance and influence the situation, is agentic because the situation is ambiguous and a number of options and actions are possible and the agent must choose which action is best in order to act. In this situation, Diane understood her role as agent yet knew she did not yet have the "repertoire" to act without first checking out the appropriateness and correctness of her intention with an experienced nurse.

Developing agency through the action of performing physical skills

Care and concern for the patient are often demonstrated in nursing by physical acts or skills. These are physical acts done by a sentient skillful physical body for a similar, but now, compromised physical body. These skills are necessary for the well being of the patient. Successfully learning such embodied actions can only be achieved from within the enactment of the physical action as described by Helen:

> especially because so much of nursing is physical. Like physically re-positioning somebody in bed. Or physically doing a wound care, or even giving a bed bath, that is about how you physically do something. Or putting in an IV, how you physically do it. Yeah you can watch somebody put in IVs all day, but—not just putting in the IV, but what's your relationship with the patient when they're nervous and you've got the light on, and you're trying to make it as anxiety-free an experience as possible. But you

> also are kind of shaking, your hands, you know?**…** It's totally different than observing it. Because you're doing it. I mean your whole body is doing it…and it gives you confidence. I mean, we gave each other high fives when we got in an IV. It feels good to do that.

Successfully learning a skill is an exhilarating experience for the student and is often an experience that is shared, and has meaning, for the other students. In this exemplar the nursing student is very aware of the particularity of the situation. She senses the fear and other emotions of the patient heightened by the fact that the student's hands are shaking and that she has turned on an additional light to focus on the task at hand. What remains unsaid here is that if you hang the wrong I.V., or think you have successfully "hit the vein" and are actually outside the vein, you feel regret. This emotional response would also be appropriately formative given the goals and intents of nursing practice.

The student's account also highlights the embodied aspect of the skill ("I mean your whole body is doing it"). Learning skills happens from the inside out; the dexterity to perform the skill well happens from within the body as in Diane's embodied act of removing a foley catheter:

> Well, for example with an act like taking out a Foley. If you're just watching someone do it, it seems easy and seamless, and only once you actually do it yourself do you realize this or that can go wrong and you have to remember things, and as a result you have the drive to perfect it. Whereas if you're watching, there's nothing for you personally to perfect or do.

When observing the experienced nurse enact a skill such as removing a foley catheter the student observes it done with an effortless flow. It is only from doing the act on his or her own that the student gains the experience of what can go wrong, like not completely deflating the balloon on the tip of the foley cathether, and what one can do to perfect the skill.

Developing agency while providing care

In a comparable way students learn to enact care from within the experience of providing care. Physically performing the work of care for the patient solicits the student to respond to situational demands. Situated cognition and skillful responses become integrated for the student. The planning comes about organically from being within the situation and needing to find your way- this is what is meant by agency as an existential skill. It is existential because it is experienced first hand by the student. For example, in the following exemplar Lina's way of being in the situation, her efficacy and agency, have been transformed in ways that she felt and experienced as a newly gained capacity:

> So with the hands-on, with the medsurge, the reason why I like it is because that's how I learn. I **do** the work, right? So anything that I find I have to follow up with….for instance last week I had a patient who had a order for Metoprolol at eight o'clock at night. It was a one-time thing. And [I] took her blood pressure throughout the day and it just kept slowly rising. So I had to follow up with a physician and go, "Look, her blood pressure is 165 over 70. Should I, I think I'm going to give the Metoprolol now. This is high, you know." So I don't know if that makes sense but I was the one who found it. I was the one who addressed it and followed through and I ended up giving her medication early.

Early in this exemplar the student transitioned to a more authoritative stance mid-sentence, in making her case to the doctor that a patient needed to have a medication given early. She began the sentence with "should I" and then transitioned to "I think I'm going to" to further clarify her stance. She strongly felt her agency in the situation. Within the situation no other option could be acceptable, she ***must*** be the one to follow through and she did. As she did this, she felt herself ***being*** a responsible nurse. Her identity shifted from being a student who observes and learns to one who takes action and follows through. Her skill and agency were now integrated with doing the right thing for

the patient. She was able to contrast her newly won "insider" stance in comparison to an earlier clinical situation where she was only an onlooker:

> [Whereas], In labor and delivery the nurses'll let you do things and they'll show you how to read the fetal heart strip and you can do that and you can make your observations. But you don't, you're not touching the pit, you're not touching any of that. Not that I wanted to, but you're not doing any of that aspect of nursing care. I wasn't communicating with the physicians. I wasn't "Oh, I'm noticing something and I have to call a physician". I didn't take a part— I remember…one of the women who I watched give birth. When she started going into active labor, my preceptor was the one who called the team to get everyone in there so that everyone was prepared to have the baby. And I didn't really understand- all of a sudden, why now? You know it didn't make sense for me. I mean, in hindsight now that I know more about that I get why we called Peds and I get why we called when we did, and all that stuff. But I didn't feel like I was as integral. I felt like I was an assistant and helping out. Whereas in Medsurg, you're actually doing the work. You're charting everything you find, you know? And you have someone supervising you, but you're doing it, and anytime you need—I mean they're depending on you to reach out when you need help. And to ask questions if something doesn't seem right. You get to pull the medications out. There's just something different about getting that experience, even like making sure that you're pulling out the right meds, as opposed to someone saying here go give this Vicodin to so-and-so…you have to double-check everything and things start making sense**…**I guess it makes a really big difference when you're in charge…for me I just feel much more forced to think critically.

Lina's comparison of labor and delivery and medical-surgical nursing demonstrate for her and for us, the requirements for experiential learning where one's identity and a sense of agency are formed and remembered through being responsible for actual interventions, and for being depended upon as integral to the team and to the care of the patient. That Lina remembered her recognition of the patient's high blood pressure, and called the doctor in order to give the medication early, shows that it held significance for her. It is a benchmark- one of those events where she began to feel like a nurse. Later such events will not be as memorable as they take their place as just 'all in a day's work' as a nurse.

Learning to communicate with the team while enacting care

The student's view of the communication skills needed to effectively provide care for the patient is enhanced by the charge to independently care for patients:

> One of the biggest things I've learned is, how do you communicate with the rest of the team? When you're doing care on your own, rather than listen to your nurse talk to the doctor you actually have to talk to the doctor, call respiratory therapy, or just kind of figure out, "how do I work with dietary if I need to change something?" And being in charge of those things, or having to discharge someone and actually do[ing] that. I've learned a lot in terms of how to navigate the hospital itself, which makes giving care so much easier in general. Because rather than, "oh I have to figure out if this order's okay and we have to wait for someone", you're just like "oh I'll just go talk to the doctor." It's just so much easier. And at first it's a little intimidating to reach out to these different parties. But then you do it a few times and you're like oh it's easy. It's a lot easier than you think it is. It's clearer. I see the network of the hospital much clearer now than I did before. Whereas [before] I felt like I was kind of floating and not really interacting with these different parties.

Inez's sense of responsibility to provide effective care propelled her to communicate with other members of the health care team. In this case her sense of her own agency overcame her prior feeling of intimidation. Inez understood the network of people involved in care, and the particular aspects of how to communicate with these people enabled her to give more effective care. Learning how to talk to doctors, learning why and how to call a respiratory therapist, and learning how to work effectively with dietary when a change in diet is ordered are all existential skills the student took up for the sake of the patient. The student's care of the patient was also more efficient as it took less time when treatment decisions weren't filtered through the nurse as conduit. The student felt more anchored to the network of care providers through the concrete experiences of managing the care of patients. She was no longer "floating" but felt like an insider—a participant member-- in the health care team.

Navigating with a need in mind: where to go and who to get

As part of learning to navigate in the clinical environment the student also takes up the skills of where to go and who to get for expert help with particular aspects of care. When asked about what he had learned from caring for patients independently, Ed described these aspects of his own resourcefulness for managing equipment and the particulars of a patient's diagnosis:

> and also being resourceful is something that you get out of it. Because you know, if they've got a lot of stuff hooked up to them, a lot of times some of that stuff needs to be changed, and as a result of having to be responsible on your own you kind of learn what shit is, and you learn who and where your resources are. Like this great nurse on our unit. He's an LVN actually, but the guy is a wound stud. He knows everything there is to know about wounds. Don't ask any nurse before you ask him… I mean no two wounds are alike, right? And he really broke down [for] me how you can have one type of wound in one area of this larger wound, and another type of, and you know, how to care for that. And he was an L.V.N. And just automatically you assume R.N. over L.V.N. But he was the guy. And everybody knew he was the guy... Who's the IV person? I know who that is also. And she trained me so well to stick IVs, you know?

Ed's need to cope with the intricacies of intravenous equipment as well as wound care led him to seek out the "specialists" within the unit culture of care. The "wound stud" had gained a reputation based not on the title of his role, but rather on his ability to describe and treat the qualitative distinctions in types of wounds. The "IV person" could teach Ed the expert techniques of IV starts. The student was gaining an insider's sense of the local and specialized knowledge within team members on the unit.

Gaining familiarity, autonomy, and confidence

When providing care to the same patient for two consecutive days the student gained familiarity from one day to the next and learned the particular needs of this patient. On the second day the student incorporated her learning into a care routine that

was smoother than the day before. In the following exemplar, Carol has gained familiarity with the patient situation and this familiarity added to her sense of comfort and confidence:

> I've worked with him and I spent the morning getting used to crushing all of his medications and calling the pharmacy to see which ones could be crushed and changing the forms for the ones that weren't crushable--just spending my time learning how to care for this patient…By Friday I felt a lot more confident about taking care of him and having an idea of how I should manage my time…Because I was familiar with his medications, familiar with what was required for his care, like checking his wrist restraints for circulation...So I felt more comfortable.

Working with the same patient for two consecutive days allowed the student to become familiar with physical aspects of care ("crushing all of his medications; checking his wrist restraints for circulation"), extending her theoretical understanding of the medications ("calling the pharmacy to see which ones could be crushed"), and gaining a better understanding of the hospital culture through her discussions with the pharmacist. This student was also integrating the internal good of nursing practice that care should improve daily based upon situated experiential learning. She was learning to develop a self-improving practice

Many students feel a sense of empowerment through their ability to care for patients on their own. This autonomy encourages the students' confidence. In this exemplar, Ed's independence made him feel more confident as he recognized that he could navigate the rough ground (Dunne, 1997) on his own:

> Totally on your own? Yeah, being completely independent, flying solo, as I call it, builds your confidence. I can handle this, is what you get from it. Particularly if you pick a patient who needs a whole lot of different stuff. You know, they've got the rebreather mask on, they're getting a tube feeding, IV meds that you have to hang. A lot of us really don't like hanging IVs, by the way. We have to stick IVs on them, or do blood draws, q4 hours or whatever, just being responsible for that, all that stuff, and

> actually having to do it doing it and accomplishing it builds your confidence so much, and I think it's important for everybody to at some point in time fly solo, preferably on a high acuity patient. On a really sick, unstable patient. That's important. So that's an intangible.

Flying solo within the care of a high acuity patient is a high stakes situation and handling this responsibility effectively builds confidence in the student. However, clinical faculty need to remain vigilant and remind students that the goal of independent care should never take precedence over patient safety. For beginners, caring for a high acuity patient requires dialogue with a clinical instructor and the staff nurse ultimately responsible for the patient. Ideally a staff nurse and the student should perform as a team with the student planning and enacting care, but in close collaboration with the staff nurse as safety consultant. In Ed's account it is unclear how "solo" he really was and whether a staff nurse, as safety consultant was close by, unbeknownst to Ed.

Gaining trust from staff

The ability to care for patients independently is noticed within the unit culture of the floor, provided the student is assigned to the same unit over time. This reputation can lead to an unanticipated reward:

> The resourcefulness, the confidence, and I think you kind of build a reputation off of being able to fly solo. Oh he can handle really acute patients. He worked last week with Mrs. Nine Bed One. He can handle it. He could probably also then handle Three Bed Two, you know? —and these nurses talk amongst each other, so you build yourself a reputation, and you know, you'll work with another nurse and you automatically have trust. So that's an intangible, and really sweet thing that I got out of it, was that I got a good reputation on the unit, and a nurse manager talked to me about a potential job opportunity this summer, you know, so, yeah. Because you know, they trusted me, and I gained that trust by flying solo, by being solely responsible.

Over time the nurses on the clinical unit have an opportunity to observe students enacting care. In this way the nurses can develop trust in a student's abilities even before the

nurse and student share a patient assignment. However, in this account Ed's criteria for flying solo successfully seemed based on managing many complex tasks with the patient represented as an object ("Mrs. Nine Bed One") to be "handled". In the prior exemplar as well, Ed's focus was on "stuff" and tasks: rebreather masks, IVs, and blood draws. Confidence during experiential learning is fragile. While it is important for the clinical instructor to support the student's growth towards autonomy, at this juncture it would have been beneficial for the clinical instructor to pay closer attention to the student's performance and dialog with the nurse the student had been "buddied with" to find out what a nurse in close proximity had observed. Situated coaching would have been useful to Ed at this juncture to pull his focus from the tasks and "stuff" to a more coherent account of the patient's clinical condition, and the goals and risks of the patient's current clinical condition and responses to the therapies being administered.

Prioritizing and managing time

An existential reality is that when managing the care of two patients the student has less time available to spend in either patient's room. Students often interpret this as a motivating force to become more efficient in their organization and prioritization so that they can have more time to attend to the patient other caring ways. Diane noted:

> And so having that responsibility has changed to a certain extent the way I operate. And I think some... changes are that, I think that I dote on patients less. You know, the patient care is the goal, and I'm there for them in a myriad of other ways, but I'm not going to spend my whole day in the patient's room. Just for one thing, it's just physically an impossibility when you have two patients. But also because I am getting better at time management and prioritizing and so forth. And so that's been a big step. More confident in my assessments in a way that I wasn't before.

These students knew they would seldom have single patient care assignments as staff nurses, though this was often the case early in their nursing education. Diane realized that

she could not longer spend extended periods of time with the patient yet she understood that the care of the patient was central to her role.

Discussion

Student accounts of taking up the practice of nursing include many taken for granted aspects of every day coping in the clinical world. Students in this study often used the term navigating to describe existential skills such as skilled know how, grasping the nature of the situation and it's appropriate ends, and skillfully navigating a clinical situation through the development of a style of their own used to guide and orchestrate their actions in particular clinical situations. According to Hubert Dreyfus (1999), the three interrelated and foundational aspects of human intelligent behavior are: "the role of the body in organizing and unifying our experience of objects, the role of the situation in providing a background against which human behavior can be orderly without being rule-like, and finally the role of human purposes and needs in organizing the situation so that objects are recognized as relevant and accessible" (p.234). In this description of human phenomena it is apparent that the actions and emotions of humans cannot be separated from the context in which they occur.

As well as an articulation of MEPN students' developing skilled know how, this research describes the students' developing clinical agency gained through concrete experiences in relationship with patients and families, other students and clinical faculty, and health care professionals. Being responsible for outcomes solicited the students to pay attention in ways that things and equipment "show up" that were not obvious before. The students gained a sense of initiative to ask more questions in order to deepen understanding of the clinical picture. The additional guidance of meaningful emotions as

the students took up "the gravity" of their responsibility increased their vigilance, attentiveness and initiative to learn ("why I wake up in the middle of the night concerned about something that I forgot"). Being responsible for the care of a patient allowed the student to develop a personal style of care ("your own way of doing things"). Often this style bears a family resemblance to the styles they have seen modeled while being alongside experienced nurses, however it has been altered and embodied to fit the individual student's being-in-the-world. Forming one's own clinical agency is never achieved in the abstract but through direct responsibility, navigating concrete clinical situations with real risks, and developing the appropriate knowledge and skill *to act in and influence* clinical outcomes.

Implications

Developing agency and responsibility through independent care

This research uncovers a rich description of students' developing sense of agency and responsibility through caring for patients as the primary provider of care. However, as noted by one student, when students enact care relatively independently rather than alongside a nurse "it's riskier for patients". Today patients in most medical surgical unit are sicker, have more co-morbidities, and shorter stays. In addition, clinical faculty often depend on staff nurses to provide direct oversight of students and this staff are seldom provided with pedagogical training.

One student in this study voiced a tacit and taken for granted aspect of clinical practica; what is meant by 'managing two patients'? Without clear definitions of the expectations for providing independent care students might focus more on the outward

manifestations of efficiency in the managing of multiple, complex tasks rather than focusing on the efficacy inherent in care for the particular patient.

Many of the students in this study took a position of hyper-responsibility that implied a program expectation of high independence. In fact, this researcher frequently asked if the clinical instructor was available for advice, and the answer was most typically 'yes'. It is possible this high level of independence was in some way attributable to their former lives of responsibility and success in academia as well as careers. However, clear program guidelines about the level of independence anticipated could reduce students' performance anxiety and also increase patient safety.

Students, especially in accelerated programs, could benefit from providing more independent care in subacute settings earlier in their program of clinical practica. Post partum units with healthy moms and babies or skilled nursing facilities with relatively healthy older adults can serve as venues for students to develop their sense agency and responsibility in a 'safer' setting. Each case would require the clinical instructor or charge nurse to prescreen patients to select those that are subacute and should include frequent reports from the student to a "buddy" nurse with findings and an updated plan of care. Pre-clinical dialog with the staff to introduce these expectations as protocol would frame these frequent student "check-ins" as guided by patient safety concerns.

The significant role of clinical faculty

During this study's clinical observations this researcher noted an untoward disruption of the students' patient care routines when clinical faculty presented on the unit. While this, to some degree, is inevitable given the distribution of students on multiple units, it is important that clinical faculty establish a presence and expectation

that the faculty role does not focus on evaluating students' capacities to practice tasks such as medication administration, IV starts, dressing changes, and inserting foley catheters.

Each time clinical faculty reappears on the unit, he or she can encourage the students' understanding of the practice by questioning students about their patients in such a way that significance is brought up from the background. While these questions can have meaning for the student working alongside a nurse and performing tasks, their significance is greatly increased while the student is responsible for more independent care of the patient. Such focusing questions within specific clinical situations have been called situated coaching by the Carnegie National Study of Nursing Education (Benner, Sutphen, Leonard-Kahn, & Day, In progress). Lisa Day, one of the paradigm cases of excellent teaching within the Carnegie study, structures both her classroom case studies and clinical teaching around these questions: 1) What are your concerns for this patient? 2) What are you planning to do to cope with these concerns (What will you watch for? What nursing actions will you perform? What lab work will you look for? What tests do you anticipate will be done? What else are you concerned might happen?) 3) What are the patient's concerns? and 4) Who/where are your resources? Coaching focuses on bringing up from the background what is necessary for the student to notice and attend to in learning a complex practice such as nursing. In addition, it develops a routine and expectation from the student that this is a primary role of clinical faculty.

Finally, even before students are able to perform independent care of patients their care can be guided by faculty such that observations and tasks take on meaning through a focus on the patient. If students are taught skills effectively from their

beginning skills labs, and later when performing these skills on patients, these intimate moments with patients can open up the student's understanding of the patient's particular concerns as well as provide opportunity for focused physical assessments. This notion contrasts with students' articulated desire in the studies by Cangelosi and Kohn & Truglio-Londrigan For example, one student in the study by Cangelosi complained that too much repetition in practicing skills such as bedbaths impeded her accomplishing "real learning tasks". Physical nursing tasks performed on patients need not be mundane but can instead challenge students to discover all the ways they can learn about the patient, make more holistic assessments, and develop the patient-nurse relationship. While spending time engaged in tasks such as bedbaths, students can learn what the illness means to the patient, how the patient's social and physical environment might support or hinder the process of healing, and what the patient projects as possibilities beyond this hospitalization. Students can take the opportunity to perform a more thorough skin assessment as well as to observe musculoskeletal function as the patient moves in bed. What is important is that students notice the particular patient while performing these skills and thus extend their theoretical learning through experiencing care within a particular patient encounter.

While often taken for granted faculty's intention to "shine a light" on the ultimate good of the healing arts in concrete cases can provide guidance toward students learning the practice. Through the direct care of patients, students develop a sense of agency while learning to individualize care and maintain patient safety. The challenge for clinical faculty is to structure clinical practica so that students can develop their own ability to act and be responsible for patient care within a safe environment.

CHAPTER 7

CONCLUSION

> It is significant that "culture" is sometimes described as a *map*; it is the analogy which occurs to the outsider who has to find his way around in a foreign landscape and who compensates for this lack of practical mastery, the prerogative of the native, by the use of a model of all possible routes. The gulf between this potential, abstract space, devoid of landmarks or privileged centre…and the practical space of journeys actually made, or of journeys actually being made, can be seen from the difficulty we have in recognizing familiar routes on a map or town-plan until we are able to bring together the axes of the field of potentialities and the "system of axes linked unalterably to our bodies, and carried about with us wherever we go", as Poincaré puts it, which structures practical space into right and left, up and down, in front and behind. Pierre Bourdieu (p.2)

Condensed and accelerated

This research study uncovers significant background understandings of how students in an accelerated second degree program experientially learn the practice of nursing. The quote by Pierre Bourdieu aptly mirrors the embodied "journey actually being made" of these accelerated students through the landscape of clinical practice as they take up existential skills of nursing practice and learn to get around in what is a new territory with new demands. This landscape includes intersecting aspects that occur within the situated context of a condensed and accelerated curriculum. It also includes students' developing "practical space" of responsibility, agency, and skilled know how that form an emerging identity as a nurse. They are being formed to work for the good of patients' possibilities for health.

It is the phenomenological paradox that the person both constitutes and is constituted by situations and commitments within the concrete experiences of practice. Students in accelerated programs come with prior experience of mastery in an academic setting and often have had successful, varied and challenging career trajectories as well.

When they enter the clinical world of nursing practice, students experience being novice again. Being a novice is similar to being a tourist or new immigrant who does not yet know the common language, habits and practices, or how to get around in a new environment. Foreigners do not know how to negotiate or dwell comfortably in the world with understanding and a perceptual grasp of what is meaningful and more or less significant. They are confronted with new physical demands, new equipment, new time patterns, and, most importantly, new ways of relating to people, all within a condensed time frame. Students are struck by how much they don't understand, yet what stands out in these students' accounts of "doing things I've never done before" is a context where people's lives are at stake.

Learning an underdetermined clinical practice requires concrete clinical cases. Clinical situations as lived by the student in an accelerated program often turn out differently than the student's preconceptions. As Gadamer (1975/2004) noted, experience means being turned around in one's pre-understandings or expectations. This notion of 'being brought up short' (Kerdeman, 2004) is particularly significant in the context of the care of the sick and physically vulnerable.

Developing a sense of agency and responsibility

Students identified the independent care of a patient or patients as one of the formative experiences in the development of their identity and skill as a nurse. In Chapter Six, the student participants articulated their developing ability to act and affect clinical outcomes through the concrete experiences of involvement with particular patients in their clinical assignments. Being responsible for outcomes solicited the students to pay attention in ways that things and equipment became apparent that were not obvious or

salient before. Students also learned physical skills through these skills of involvement with patients, families, and co-workers, and ways to integrate theory in the service of providing care. Often these skills developed concurrently, such as in Helen's account of learning the physical skill of starting an IV. Helen's awareness of her own emotions and the emotions of the patient demonstrated her involvement with that particular patient, as well as the embodied skill of IV insertion. Her account also highlights her involvement in the developing community of practice with her peers as they gave each other "high fives" for successful physical skills enacted.

The role of emotion in learning nursing practice

The notion of the gravity or emotional weight of what is at stake in the clinical situation stood out in the narrative accounts of students. This emotion as a part of the individual's embodied response within a concrete clinical situation is often covered over and taken for granted once the person has learned to feel at home and act in the new environment. Even a well orchestrated and well acted simulation scenario, whether with live actors or computer generated manikins, will unlikely solicit the same embodied emotional response from students. This view of the role of emotions in perceptual grasp and the practical interpretation of the situation is well articulated by Damasio (1994).

Simulations are a noteworthy "adjunct to clinical nursing education" (Nehring, 2008). In the current climate of faculty shortages, shortages of clinical sites, and shorter patient stays, and higher patient acuity, simulation is an effective high fidelity substitute to direct patient care for some clinical situations. To a degree simulations can mimic real life in a safe environment that gives the student time to rehearse and consider possibilities in preparation for the real clinical situation. Simulations can be especially effective for

rehearsing emergency situations that the student or certified clinician might rarely encounter. However, the uncertainty and ambiguity of the clinical environment cannot be duplicated, and more importantly the emotions evoked in taking responsibility for clinical consequences cannot be fully solicited in simulation. Simulations should be constructed with enough ambiguity for the student to have to ferret out what is most significant in the clinical situation, but of course, in simulations this will always be clearer than in actual clinical situations.

Significance of clinical faculty role

This research underscores the important and pivotal role of clinical faculty, guiding the student towards more independent practice but never at the expense of patient safety or a student's mistaken perceptual grasp of what is significant in a particular patient encounter. Clinical faculty can encourage the students' understanding of the practice by frequent questioning of students about their patients in such a way that meanings are brought up from the background. One of the problems of practical reasoning is that it depends on recognizing the nature of the situation, i.e. what stands out as more or less important (Bourdieu, 1977), but this grasp of the nature of a complex and under-determined clinical situation eludes the novice who has little experience with different clinical situations. Therefore, coaching the student and helping them interpret the situation is central to situated cognition and developing clinical reasoning (a form of practical reasoning about changes in the patient and changes in the clinician's understanding of the patient over time) in a particular situation (Benner, Hooper-Kyriakidis, & Stannard, 1999). Even prior to performing independent care of patients, students' care can be guided by faculty in such a way that the student can focus on the

patient and the concerns and notions of good relevant to the patient. If students are taught skills effectively as more than de-situated psychomotor skills, intimate moments with patients can open up the student's understanding of the patient's particular concerns, and also provide insights into the cultural expectations for the relational aspects of being a nurse.

Students sometimes spoke of "performance anxiety" and nervousness about their ability to respond to "on the spot" questioning. Faculty can decrease this anxiety by framing and enacting this dialog as an expected routine with pedagogical importance not primarily rooted in evaluation, but rather as guidance to open up the student's understanding of the clinical situation.

Formation

The term formation to describe the transformative education of practitioners evolved from pedagogical language used in the education of the clergy (Foster, Dahill, Golemon, & Tolentino, 2006). In 1995 the Carnegie Foundation for the Advancement of Teaching embarked on a nation wide study of professional education, across the professions of clergy, engineering, law, medicine, and nursing. The researchers were intent on uncovering similarities as well as differences in the education of each practitioner, and aimed for dialog between researchers so that the best pedagogies of each could be shared with the other. The study began with an understanding of the taking up of a professional practice as anchored in three apprenticeships: cognitive, skill based, and ethical. However, contrary to the oft stated learning domains of cognitive, psychomotor, and affective skills, in formation the three apprenticeships cohere within and through the concrete experiences of, in this particular case, providing care for patients and these

experiences are formative in that the students' skilled know-how, clinical reasoning, and ethical comportment *form* new possibilities, capacities, character, and identity.

Benner et al (Benner, Sutphen, Leonard-Kahn, & Day, In progress) noted that across the study of the five professions, only nursing students are placed in such high stakes situations (health, life, and death) from the beginning of their training. This is especially prevalent in accelerated programs in which students are often within clinical settings from the first or second week of their program of study. It is from within these concrete cases of experiencing life and death, vulnerability and suffering, and health and healing that the student transforms to a nurse. Thus the student forms integrity as well as identity in the taking up of a professional practice (Foster, Dahill, Golemon, & Tolentino, 2006) as noted in Helen's description of becoming a nurse:

> I'm feeling right now like becoming a nurse is more than just… learning a specific set of skills or knowing a specific set of physiology or something, that it is, it's actually like a change in your person…it really is… apprenticeship in the sense that… there's a mentor and then there's someone who comes afterwards that you kind of follow the model that's set out before you. But it's much, it's almost like more artistic than it is scientific…it's more than just knowing a specific set of knowledge or skills. That it embodies who you are, how you're looking at situations, being aware of how you respond to situations, which is I think things that you pick up by watching other people. By watching other people do it well, and you want to be like them, or watching people not do it well, and realizing it's not how you want to behave in a clinical environment in the future. But a teacher in the front of a classroom can't teach you that, can't give you that example. But there's a mannerism I guess of how that, how you interact with patients for the sake of their good, and for the sake of their healing…that's not something that you're going to read in a book.

The articulation of taking up the practice of nursing as formation is distinctly different from the notion of taking on the knowledge, skills, and attitudes of the professional role as predetermined, distinct, and differentiated traits or roles that are added on much like additional possessions of the person. The term formation aptly

describes this taking up of the practice's moral ground as well as taking up the existential skills of and deeply identifying with the practice as in being a nurse. Formation articulates professional identity as constituted by what one does, and includes a continual re-formation as one takes up experientially more of the background understanding of the practice (Benner, Sutphen, Leonard-Kahn, & Day, In progress).

Future research

Further studies could articulate the different sources of learning for the accelerated student within the clinical environment. For example, for this group of students it was evident that much of their clinical time was spent guided by a nurse with whom they were paired on a particular floor. There is much to unpack about how this relationship develops and changes over time. Such an articulation is especially valuable given the current constraints on the numbers of clinical sites and clinical faculty, necessitating that the assigned clinical instructor often has students assigned to three or four different floors, making it difficult to spend more than a few hours a day on each unit. Student participants in this study relied heavily on clinical staff nurses for guidance in their developing practice yet these preceptors had little if any formal preparation for teaching. Not all staff was willing to act as preceptors, and yet lack of other experienced staff sometimes necessitated students being paired with these reluctant teachers.

Additional taken for granted sources of learning are patients and families. Students spend long periods of time with patients while having little experiential or theoretical background to ground their learning, especially as rank beginners during the first weeks in the clinical setting. Further studies that focus on narratives of students' time in the patient's room with family and patient could increase the background

understanding of aspects of the practice taken up during these encounters. Patients with chronic illnesses often teach the student a lot about the management of and coping with their chronic illness, or disability (Benner, Sutphen, Leonard-Kahn, & Day, In progress).

Finally, second degree students in an accelerated program form an intense but extremely useful learning community for each other. As described by this study's participants, "the students are the best part of this program." For example, one student described how a peer's past experiences and skill set translates into more effective work with patients, aided as well by her bilingualism. The students' rich and varied backgrounds, intelligence, shared goals and beliefs, and their intensity all contribute to enriching their shared experience of taking up the practice of nursing in an accelerated learning community (Lave & Wenger, 2006). Further study could interpret the students' accounts of the meaning of this source of learning. The interpretation of individual students' accounts could extend clinical instructor's understanding of how accelerated students take up the practice of nursing in ways that might be different and or similar than generic students.

From this study, it appears that second degree students feel more responsibility sooner than the generic baccalaureate student. These students enter the program intensely motivated with a background of high accomplishment and hard work. The expectation of both faculty and students is that these students are primed for success in an accelerated program. Also in the background is time pressure; an expectation that the students will be 'ready' to enact the staff nurse role by the end of the first year. Likely the confluence of these aspects are at play in the students' early and earnest sense of responsibility. Their background of assuming responsible work roles may also add to their readiness to take on

responsibility. What is significant, yet taken for granted, for clinical faculty is to encourage the students' developing sense of agency and identity while guiding the student to develop a practice that accepts the safety nets necessary in 'high stakes' experiential learning. When students inappropriately expect to be responsible for all the knowledge-skill to care for individual patients from very early in their programs, they may need to be reminded of the safety nets that are in place, though sometimes not felt or seen by these novice students who often feel hyper-responsible. The challenge for the clinical teacher is not to disturb the student's engagement and sense of responsibility that is so central to the student's identity, skilled capacities, and knowledge use. This can be accomplished through a consultation model of teaching/learning that emphasizes lifelong learning and patient safety practices.

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APPENDIX A

University of California, San Francisco
Consent to Participate in a Research Study

Study Title: Describing and interpreting nursing student's clinical judgment at the patient's bedside

This is a research study about how student nurses learn to make judgments about their patients care while engaged in a clinical practicum. Susan McNiesh, RNC, MS is a doctoral student in the School of Nursing at UCSF, and her research is being supervised by Dr. Patricia Benner from the Department of Social and Behavioral Sciences. One of the study researchers will explain this study to you.

Research studies include only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions, you may ask the researchers. You are being asked to participate in this study because as a student in the Masters Entry Program in Nursing (MEPN) at UCSF you are involved in an intensive and integrative clinical practicum.

Why is this study being done?

The purpose of this study is to describe and interpret nursing students' understanding of how they develop clinical judgment at the patient's bedside during clinical practica. Clinical judgment is a complex yet taken-for-granted human activity. A gap exists in our understanding of the student nurse's journey to learn the knowledge, skills, and attitudes that form clinical competency.

How many people will take part in this study?

About fifteen people will take part in this study.

What will happen if I take part in this research study?

If you agree to participate in the study the following will occur:

- The named researcher will interview you twice in a focus group of 4-5 students for 90 minutes in a private setting that is convenient for you. You will be asked questions about how you make choices about patient care during your clinical practicum day. Two additional interviews will be individual interviews between you and one of the researchers. The interviews will take place over the course of the current school year.
- The researcher will make a sound recording of your conversation. After the interview, someone will type into a computer a transcription of what's on the tape

and will remove any mention of names. The sound recording will then be destroyed.
- Because it is sometimes difficult to be aware of or recall some of your specific actions in the clinical setting, Ms. McNiesh may also observe you once during your clinical practicum days. This observation will last 1-2 hours. You will be notified at least 24 hours in advance of the observation

How long will I be in the study?

Participation in one each interview will take 1-2 hours. If after these interviews (not more than a total of four) the researchers would like to schedule further interviews you may be asked to be re-contacted at a future date pending CHR approval. You are free to refuse permission to be re-contacted.

Can I stop being in the study?

Yes. You can decide to stop at any time. Just tell the study researcher right away if you wish to stop being in the study.

Also, the study researcher may stop you from taking part in this study at any time if he or she believes it is in your best interest, if you do not follow the study rules, or if the study is stopped.

What risks can I expect from being in the study?

- You might feel some psychological discomfort during the interview, perhaps feeling a loss of words. Be assured that the atmosphere will be informal, there are no "right" answers, and you will have plenty of time to collect your thoughts.
- You can ask the researcher to stop the interview at any time if you feel uncomfortable
- Likewise, you might feel some anxiety while being observed in the clinical setting. Be assured the information collected will only be used for the purpose of this research and will in no way reflect on your status in the course or be conveyed to the course instructor. You can ask the researcher to stop at any time.
- For more information about risks, ask one of the researchers.

Are there benefits to taking part in the study?

There will be no direct benefit to you from participation in the study. However, the information you provide may help researcher understand how clinical judgment develops experientially during nursing education and could provide the scaffolding to improve current clinical teaching methodologies.

What other choices do I have if I do not take part in this study?

You are free to choose not to participate in the study. If you decide not to take part in this study, there will be no penalty to you and it will not affect your standing at UCSF.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include:

- UCSF School of Nursing
- UCSF Committee on Human Research

What are the costs of taking part in this study?

There will be no costs to you as a result of taking part in this study.

Will I be paid for taking part in this study?

You will be given a $15 gift certificate in return for your time and effort in the study.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way.

Who can answer my questions about the study?

If you have any questions, comments, or concerns about taking part in this study, first talk to the researcher (Susan McNiesh, (831)423-3425 or mcniesh@cruzio.com) or Dr. Patricia Benner, RN, PhD, FAAN, (415)476-4313 (patricia.benner@ucsf.edu). If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the **Committee on Human Research**, UCSF's Institutional Review Board (a group of people who review the research to protect your rights).

You can reach the CHR office at **415-476-1814**, 8 am to 5 pm, Monday through Friday. Or you may write to: Committee on Human Research, Box 0962, University of California, San Francisco (UCSF), San Francisco, CA 94143.

Consent

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to participate in this study or to withdraw at any time without penalty or loss of benefits to which you are otherwise entitled.

If you agree to participate you should sign below. You have been given a copy of this consent form to keep.

_____	_____
Date	Signature of Study Participant

_____	_____
Date	Signature of Person Obtaining Consent

Appendix B
Background Information
University of California, San Francisco

Study: Describing and interpreting nursing student's clinical judgment at the patient's bedside

Name:

Gender:

Age:

Ethnicity:

Education:

Prior medical experience:

What were you doing for the last year before entering this program?

When did you start the MEPN program?

Appendix C

Interview Guide- Individual

1. I know you began your first clinical rotation this summer. What was it like to enter the practice for the first time? Describe for me everything you can recall about your first clinical day in the same way you might tell a friend or family member. Try to put yourself back there and tell me the story giving me as many details as you can recall.

2. Now consider the entire summer clinical experience. Tell me about a clinical day or situation from that period of time that stands out in your mind as pivotal. Relate it like a story with as much detail as you can recall. (Probe)- What were your clinical goals for the patient and how did you accomplish them? (Probe)- What were the patient's concerns?

3. Describe a patient encounter where something happened that you didn't expect.

4. What were your expectations of this program before you began? Have your expectations changed, and if so, how?

5. What aspects of taking up the practice of nursing do you think have been most difficult for you? How and why do you think this is so? What about your classmates- do they have similar or distinctly different issues from the ones you have encountered? How do you understand that?

6. Is there anything else you think I need to know?

7. Are there any questions you'd like to ask me?

Appendix D

Group Interview Guide

1. Tell about the experiences that you brought from your former career or educational background, particularly how you thought these experiences might influence your taking up the practice of nursing.

2. Describe a clinical learning situation that taught you something new about yourself as a potential nurse, or something new about nursing. As much as possible, tell the story of what happened.

3. In what ways do you think this clinical rotation has supported your learning to be a good nurse? (Probes: Are there any particular people, situations, or aspects of the culture of care that have aided your preparation?) Looking at the same context, can you describe the downside or hindrances posed by a particular person, situation, or other contextual factor?

4. What brought you into nursing?

5. Is there anything else you think I need to know?

6. Are there any questions you'd like to ask me?

Thanks you for your time and thoughtful responses.

For the second group interview cover any of the above questions that weren't touched on in the first interview. Also will include clarifications and other questions that have come up in listening to the first interview. In addition:

7. I asked in the last interview for experiences that you brought from a former career or educational background that you thought might influence your taking up the practice of nursing. Has your perception of that changed since that time and if so, how?
8. Tell me about a recent clinical experience that you think you really learned from.

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