

Evaluating Narrative Pedagogy in Nursing Education in Hong Kong

Key words: Caring, sustainability, personal knowledge, theory enhanced practice

Abstract: As a nurse educator who taught students of caring concepts and theories, narrative pedagogy was adopted. I learnt with students their translations of meanings of caring into practice and their sustainability within a health care structure that remains predominately biomedical and business oriented. Focus group interviews were conducted after students' completion of the course. It was clear that a professional nursing identity within a human science paradigm rested in graduates' continued retelling and reliving through reflexivity of their caring narratives. The importance of theory enhanced practice from a pragmatic approach is essential for graduates to sustain their caring practice.

Introduction: The statement that nursing is both an art and a science has been well established in nursing literature. Caring is being considered as an integral part of nursing. Defining caring as part of nursing competence for graduates who are expected to continuously live and grow in caring within the dominance of a biomedical and technological context is hence important for both our nursing identity and the development of our professional knowledge. This notion is certainly not new, historically, caring has given the nursing profession its identity. (Reverby 1987). However, it remains an issue of struggle among nursing students in my class of caring concepts.

As a nurse educator teaching a course on caring concepts to students in the post-graduate baccalaureate nursing degree programme, I adopted the narrative pedagogy in teaching caring theories with an emphasis of story sharing and peers' response letters to the stories shared by others. A [student's] personal story, according to Reissman, (1993) is "a recapitulation of every nuance of a moment that had special meaning" (p.2). Other students listened to the stories were directed to think about their selected stories to respond in a manner of thinking with stories and not thinking about stories. Severtsen et al. (2000) contended that thinking about story would inadvertently reduce the story to contents but thinking with story would allow [the students] to treat the story as a whole, and it was the lived experience of [their peers] telling it and allowing [both the narrator and the audience] to identify the meanings from the experience that were storied. Davidhizar & Lonser (2003) asserted that storytelling has been used for centuries to pass on a cultural identity, here it refers to a nursing identity. Storytelling was hence employed to assist students' learning to listen in a contextual manner for uncovering of the beliefs and values of the storytellers, their peers. Simultaneously, through responding to the stories and receiving feedback from peers, the process could help to bring to both the narrator and the audience their awareness of their beliefs and values in their perceptions and interpretations of the stories of caring and/or uncaring. The use of narrative pedagogy was therefore not only a teaching strategy but also a way to promote thinking about the meanings of the caring contents being learnt and their significance to students' nursing practice. A safe place for students was created to focus on their lived experiences of caring in practice and to examine the possible taken-for-granted issues in the workplace (Diekelman, 2001).

Nursing is a practice profession. In a pragmatic understanding, knowledge is valued for its ability to enable us as effective practitioners in our everyday nursing. Theory is often being viewed as an abstraction that has no relevance in the "real world" of nursing. Hence, many nurses would

become oblivious to the practice-theory connection, and how their existing theories may have limited their everyday actions (Doane & Varcoe, 2005). Moreover our knowledge from theory is always changing as we come to be more reflexive with our experiential learning. The process of reflexivity is an active, purposeful reflection on one's beliefs, values, thoughts, and actions, and a thoughtful action is the consequence of that reflection (Doane & Varcoe, 2005 p. 162). From a pragmatic perspective, while theory is grounded in experience (Rorty, 1999), all practice is theoretical. Using story in a pragmatic approach, Smith & Liehr (2005) stated that through the interactions among students in the process of storytelling, they came to "live in an expanded present moment where past and future events are transformed in the here and now" (p. 273). Students experience their recreated meanings as a resonating awareness as they unfold their continuous growth in caring (Smith & Liehr 2003).

The Class

In the class of the caring concepts, students were those who returned to a part-time study for their nursing degree. Many of them have had recently completed their higher diploma programme and worked as junior nurses. They were however mixed with some seasoned practitioners.

Listening to their comments and making sense of their meanings of caring as part of their assignments through online discussions, face-to-face story-sharing, writing a response letter to a selected piece of peer's story and an aesthetic expression of their meanings of caring through arts, I was intrigued to learn more as to how student translated their formal knowledge of caring as an attribute into knowledge of experience in their everyday caring practice after their completion of the course. Accordingly, students were invited to partake in focus group interviews two months after their completion of the course. (4 months for the first actual meeting to occur)

As both a learner and a teacher, I embrace the notion that learning is not merely an intellectual activity but rather a deeply embodied personal process that entails substantial experiential engagement. To become intentional competent nurses, the learning process must bring intellectual understanding (theory) together with the embodied, emotional experience (personal experience and nursing practice experience). The understanding of the way these nurse graduates integrated their meanings of caring into their daily practice is important as many of them lived in an environment where the commonplace of time issues is found in dealing with patient care. The lines about "*I just don't have time to talk to the patient, I will do it if I have more time*" or "*Talking to patient is not part of the expected tasks that I need to complete*". "*Most of the time the patients are bored except for visiting hours. But to talk I must wait till I have finished all my tasks and so it is quite difficult*". These comments were echoed by my students as some of the issues during their study of caring theories, and for many nursing practice beyond routines and tasks remains a struggling aspect.

My aim of this study was to explore with students the way they learnt to construct their meanings of caring through the course and how they sustain their caring beliefs and practice in a medically dominant context where task orientation and routine guided practice continue to prevail. The care of the patient holistically is still evolving at best, if not losing its meaning when new graduates

found themselves trapped in the expected or the convention role of a nurse living a biomedical paradigm. Bateson (2000) asserted that often we are skilled at discussing about change and transformation but not so skilled at thinking about sustaining what follows (p.32). It is an important consideration since this group of young nurses hold the future of our nursing development.

I hope that stories from the graduates through focus group interviews will not only benefit all participants involved but also will resonant with the readers some similar concerns. Collectively, we can destabilize the grand narratives about nursing in terms of caring and its time issues along with the recognition of the importance of theory enhanced practice in nursing.

Data collection

Focus groups that can generate group interaction, possible different views and insight were employed. Two groups of graduates were recruited after their completion of the course. There were five to six graduates within each group. Three to four interviews were held with each group spreading over a few months each. The first one explored their views specifically about how their learning of caring from the course had or had not influenced their practice? The subsequent ones were scheduled for the purposes of validation of researcher's understanding of the transcripts with the participants, of clarifications from the participants and for further discernment of any changes of their caring practice since the last interviews. The participants worked in several nursing specialties, and ranged in years of practice from two to over ten years.

Ethical review

Ethical review was sought through the ethical committee of the University. Explanation of the study was provided prior to receiving their consents. Participants understood their involvements were voluntary and also recognized their rights to withdraw at any point during the study.

Data Analysis

After the data collection, data analysis included an identification of both the contextual ground and the predominant themes. The themes were derived from a content analysis. Each of the transcribed documents was read initially for a sense of the whole interview. Common words, concepts and statements used were noted. Similar themes were grouped together then organized into major categories. An initial coding system was developed from the list of categories. Coding of interview texts was done through the text units (paragraphs). Text units of each transcribed document were coded by using a word or a phrase that described the content of the text units. This process of data coding was repeated for each of the documents, compared and cross-referenced between groups. The coding system continued to evolve and develop during the coding process. Both the author and her research assistant worked together in the reading of transcripts and in the coding process. Critique and consensual validation were sought from a peer colleague to verify the codings and the thematic structure delineated.

A contextual understanding of nursing practice from the participants' perceptions

The intention to “care”, as indicated by some participants, was motivated by a recent trend of patient complaint. As one said, *“In the past, I did it to avoid patient complaints as well”*, other indicated, *“But some nurses may also distance themselves in order to avoid answering too many questions from patients because of the messages they got about patient complaint”*, yet another revealed, *“I have seen colleagues trying to do less in order to avoid mistakes. There were numerous complaints on that ward so many colleagues were very worried that they would have to be accountable when things went wrong. So they were not “genuinely” caring about the patients with their hearts”*. Apart from a seemingly blaming culture, time management is certainly a priority of nursing.

Every day, nurses in Hong Kong are faced with workload and time constraint issues, a situation that seems to have lent itself easily to the practice of functional-team nursing, which promotes efficiency and task completion. The underlying assumption is that timely completion of nursing tasks translates into the delivery of comprehensive, appropriate and good care. Minen et al. (2003) criticize the functional nursing focus on task completion and the perseverance with ward routine at the expense of the needs of individual patients.

One participant said, *“In Hong Kong, you are being surrounded by many who tried to discourage you in caring beyond tasks. There was the particular ward culture with the staff, policy, senior management.... Most of the time, I was being discouraged”*.

Another mentioned that *“...the work environment was hindering me to perform a higher level of caring. For example, in the hospital where I worked...in comparison with other hospitals, we had many more worksheets...we needed to complete the sheets on a daily basis even for a stable patient.... The workload was already as heavy as it was, just as what Mark (pseudonym) said there was simply no time to communicate with patients. I have seen one of my colleagues who acted on her beliefs to care more of the patients. However other colleagues commented that she was doing “meaningless things.” The lack of support certainly has affected how some of us acted when we wanted to do more for the patients.... Some colleagues still persisted but in a less conspicuous way, like an underground activity. For those who were more overt in their caring practice, colleagues thought that they were wasting time and remarked, “...if you have got time, why don't you check the records?” The nurse supervisors would only ask whether we have gone through the record sheets and whether we have provided the specified technical care to the patients.”*

Yet another participant said, *“Everyone thinks the record sheets contain all the information. We were always being told to check the record sheets, to see whether something had been done or not. But actually, we could ask the patient directly. I have realized the importance to sit by the patient and to listen. It is not about reading their charts and running fervently with routine care and filling out various assessment sheets. This emphasis on documentation and task completion has inadvertently created a distance and a challenge from learning about the patient as a person and their needs. The management didn't understand that it was impossible to go through all the record sheets within a limited period of time. However, we were always reminded to go through the record sheets over and over again. It was a way to document the kind of care rendered to the*

patients so we have got a good record of care. But to me, the constant checking of the patient's record would just help one to perhaps better understand patient's medical history. I am not the doctor looking for the medical details. I see my role as a nurse is to be with the patients more and to listen to them, finding out their meanings of their illnesses. For the junior nurse practitioners, their foci lay much with the medical model. We nurses always complaint about the biomedical dominance, the irony was that we also were perpetuating this phenomenon."

Participants' comments were consistent with others' studies that expectations of others and institutional factors were in part the messages about what is to be valued and should be practiced within the business-driven, medially oriented context of health care. The lack of support from colleagues in this culture was common (Varcoe 2001, 2002). Although nurses talked about wanting "more time to talk with patients", emotional engagement did not fit with the overall work pattern that was focused on efficient and effective routine care. Even when nurses had time, many often chose to sit at the desk engaging with colleagues rather than with patients and families. Nurses disengaged relationally with patients, to some extent in order to make the organization work (Varcoe et al. 2003). Team allegiance is important since we rely on team work to maintain order and efficiency. Hence the focus is on promotion of collegial relationship. The graduates indicated clearly the importance of the routines and their relationship with the caring practice.

One participant said, *"In our routine work, it is very difficult to apply the caring theories and concepts that I have learnt. They were like textbook information. The routine care demanded a lot of time from us so it would be hard to find time to give "extra" care to the patients."* Another said that *if I were very busy, even when I saw that the patients sleeping without the blanket, I wouldn't have the time to go and help them right the way. But if I noticed that the patient wanted to reach out for the drawer that was quite difficult and perhaps unsafe, I would go and help. It really depended on whether I was able to notice it and the time."*

Another participant indicated, *"Perhaps it was just patient's attitude. Sometimes I was being challenged by the patients. They would ask me many questions in a very negative manner. For instance...some patients would ask why did you do it like that or I would not want it now. The latter would make it very difficult to carry out our work. For some tasks, there's a time schedule. They did not want to complete it on time even though I have explained it. And their relatives did not support us. We did everything for the sake of their welfare. They don't even listen to our explanation"*. This participant seems to have maintained the "white coat" expertise model of care delivery that is still very much an influence of the biomedical understanding of care. And there is also the reference of time and the completion of tasks. In Waterworth (2003)'s study, the importance of routine as a temporal plan for nurses and the way how nurses' routines impacted on others' routines are clear.

From the foregoing, there is an apparent tension between the dialectic of caring theory into practice, an intellectual exercise from learning and/or an embodied experience. And it also brings forth the power of the work culture that is entrenched in a medical model. Regardless of how the participants continue to relive and retell their stories of caring, their reflections on their knowledge and practice in caring keep open the dialogue of caring and their work situations. And the "negative" seems to shift as nurses had more experience. But it is not a matter of

experience but a caring maturity that they were able to become more secure with their caring values and their meanings. Followings are illustrative.

Findings

A caring shift and ways to sustain

One participant said, *“Given the experience, I was not so much affected by the negative feedback from colleagues when they discouraged me from listening or communicating to the patients.”*

Another stated, *“I wouldn’t let myself be dragged down by the negative influence. Otherwise, it would not be good for my personal growth. I believe when you wanted to improve yourself, you would be motivated to bounce from your low and continued with your belief as how you should care for the patient. I considered that was my motivation for improvement.”*

An exposure to caring concepts and theories had helped to validate and consolidate for some students, who were more experienced, their understanding of caring. For the inexperienced cohort, learning the caring concepts and theories facilitated their self awareness and value clarifications through tensions that shaped their past perception of caring behaviors into the present and future caring practice.

Participants’ reflections on their online group discussions, in-class story sharing and writing response letters to peers during the focus group interviews had led to participants’ sharing of their personal and professional growth, their caring chart with rhythms of the ups and downs that illustrated the profound shaping of their practice by both internal and external processes. The external feedback and an appreciation of caring for its intrinsic value with experience shaped how the participant engaged in any moment of practice. There was the affirmed need for a theory enhanced practice with an understanding of a continuous evolved meaning of caring. This qualitative temporality of caring dimension is situated within a quantitative perspective of time as graduates continued to live out in an environment of time measured as efficiency and control.

Personal and professional growth

One of the themes from the participants’ reflection on their ability to sustain their caring practice is an understanding of the interface between the self as a person and as a nurse in their caring moments with patients.

One participant said, *“After the course, when I encountered a similar situation, I remembered the stories from classmates. I would also think about my response letter to the storyteller in the situation when I found myself not able to practice my belief. I would reflect on the experience and this would help me in my practice next time. I learnt about my professional commitment and understood the way how I grew with the patients during the caring process. I have learnt from the patient as well, so I was not only helping the patient but also my own growth through the interactions. Remembering my thoughts and feelings in the response letter to the peer helped me to be my own gatekeeper in terms of the consistency between my espoused theories and enacted*

practice. Once when inconsistency emerged, I would re-evaluate and try to understand the beliefs and values I held. It wasn't so much about the patients but my own growth personally and professionally. For instance, I would be more aware of my judgment of a patient, who has been labeled as a drug addict. I tried to understand his need as a patient but more importantly as a person. The use of response letter has helped me to develop more self awareness, understand my own values and beliefs and how not to let my own value interfered with my care of the patient by imposing judgment. It was not about the right or wrong of their situations, but I should focus on their needs and do something to accommodate them. I learn to be more patient for me to reach this goal of caring."

Another participant stated, "In the past, I was affected by my own emotions, the pressure of the work and other external factors such as the patients. But now, I have expectations of myself that I need to be more empathetic, understanding more of the patients' emotions, from their perspectives, and will not be affected by their negative emotions. I have learnt that it is important to understand the meaning of the patients' acts."

Yet another participant said, "To me Caring is an art, an art of human relationship that the nurse treats the patients the best she knows how. I remember a story that our classmate shared a while back. She said that when the patient was sick and you measured his blood pressure, should we expect him to say thank you? Perhaps the worst yet, he might ask you to leave him alone. In the true meaning of caring it was not about how the patient behaved but the way we treated him. The course has helped me to consolidate my knowledge about caring. So, when I came across similar situations, I would try to relate to what I have learned from the course. I remember one theorist mentioned about caring doesn't only help the patients to grow but also helped me to grow. Now I realize that with more interactions with patients, I could see more of myself, it was like a mirror, seeing myself in patients and patients in me. After I have gone through the caring experience, it was easier for me to put myself into the patient's shoe. However, that was not the most important, but rather the process has helped me to think more about my own development. ...after learning from this course and seeing the way it enhanced my understanding in practice, nursing became more meaningful. I became more motivated and willing to do more. As I continued to learn caring in my nursing practice, I realized that it is an essential requirement of a nurse. Then if nursing is to be my lifelong profession, I should work hard to reach the highest level possible."

One participant echoed, "I also learnt from reflecting upon peers' sharing, and upon what I have heard and observed. Gradually, I would know what I should do to become a better nurse. When I learnt from peers' stories that the care was actually possible, I realized I should try it too. Though the granny couldn't speak, we could use our eyes to observe for their needs. When I was at the medical ward, 80% of the patient couldn't talk, and because I was new at the job, I treated them according to the rules and routines. As Benner (1984) aptly stated that while it is important for junior nurses to have a script for practice, it is important that they would not lose sight on the particular needs of the patients within a standardized care. This participant continued, "I was much inspired by my peers' courage and commitment. I realized that I would need to revisit my routine driven practice and learn how to "care" better. I recognized however, it is normal to finish all the tasks before we could have time to think of the patient's extra needs."

In the process, I realized the learning is about self and being a human. It is a personal and professional development.”

Another participant stated, “I realized that when I talked to the patient during a task, a procedure, and when I could see their smiles, those were the satisfying moments that helped me to relax in a busy ward which could be quite stressful. So it was helping others while helping myself. It was important to work out the changes little by little, encouraged oneself with the improvement since there was always so much more that could be changed. The turning point for me in my caring practice was after I have mastered the basic routines of the ward that stemmed from the expectations I had of myself and those from the others. Once when I was comfortable, I was then ready to move beyond tasks in my care of patients.

In listening to these participants, it was clear that they were able to appreciate the ways their caring theories and values translated into practice. Their ways of understanding would shape their subsequent experience. They have started to see beyond the physical body for the “true/human” self of the patient. And the aesthetic also rested in their continuous living and growing in caring. They learnt to live with who that person is, accepting that the person has good reason to choose, to express the way he/she felt. But more importantly, the process has helped them to develop meanings for their work, their personal and professional identities. The universal human issues found in nursing were very much part of their own lives as well.

However, the subtext for some has the element of time issues which transpired into routines and tasks. The theme about time in relation to care within a culture that emphasizes on routines and task completion makes sense. Waterworth, S. (2003) asserted that routines do not only provide a sense of order and control but can also decrease the thinking time needed in time management. Interestingly however, some participants would opt to think and do just a little more and others recognize that caring doesn’t have to take extra time. Hence, given the participants’ reflections on their thinking more and doing more will be a great stride since it would seem to be an antithesis to the concept of routine.

Thinking and doing a little more

One participant said, “Actually this course reminded me of a lot of things. I would consider more from the patient’s perspectives, trying to listen more of their feelings and thoughts as well as to observe more. And this would help in caring for and about the others. Sometimes, when we are at work, we wouldn’t think so much and we would perhaps miss many things that are important to the patients.”

Yet another said, “I am now less task-oriented... to think a little more and tried to do more in the care for and about the patient. I started to talk a little more or to consider a little more about all aspects of the patient before my action. It would not be only the standard pre-op teaching but trying to learn from the patients, their needs. After the course, I started to think a little more. I would say to myself that if I uttered one more sentence, the patient might feel happier and I would surely feel good. My working attitude had changed. If I were to do things wholeheartedly, patients know. Their positive feedback has helped to propel me forward.”

A caring chart with rhythms

Participants' mentions of feedback were clearly depicted as their ups and downs in their sharing of the continuous pursuit of learning and growing in caring. Caring is energy dependent, not only physical but also part of an emotional labor. Staden's (1998) findings referred a part of the emotional labor to "changing how one felt when dealing with the so called "bad" patient or appearing caring which relates to the nurse changing her own emotions to match those that the patient is displaying." (p. 152).

Caring is an experience that carries with it external and internal drivers for action, an intention to care. While not all the participants require external reinforcement, many did view the positive as ongoing fuel for them to be motivated, and to enhance their understanding of the meaning of caring in practice. Their accounts of caring reflected what they have done for/with patients and the subsequent feedback from patients.

One participant said, "*...patient's appreciation of what I had done made me feel satisfied and motivated me to care more*". Another participant said, "*The time for me to bounce back from caring after some "less positive" experience is shorter. With experience, I developed a firmer belief of what caring is all about. Gradually, especially after the course, I was able to label my caring experience. I became more confidence and courageous that I wouldn't stay low for too long. The time to regroup my feelings was shorter.*" Yet another participant's comment about her experience as a new graduate further reinforced the importance of participants' perceived confidence with experience. She said, "*When I first started to work as a graduate nurse, I was so stressed that I was very depressed. I was disillusioned as to the reasons why I couldn't integrate my theoretical learning into practice. When I am working with one patient, I was thinking about the completion of the tasks since I still have 7-8 patients to attend. I would do it very quickly. So when the ward was busy, your responsibilities were high. If you did something wrong, it would affect patient's welfare. So you would lose confidence (building professional image and identity). Hence you needed to concentrate on the task at hand and thought of nothing else. However, at the last ward I worked, if I were too busy to talk to patients, I would make a point to do it after I had completed my tasks.*" This finding parallels with Waterworth's (2003) result of which junior practitioners, who did not have had much experience or confidence, would take longer to complete the tasks and hence the time pressure intensified. The transition was definitely not easy for the nurse graduates in making unfamiliar decisions and living under immense time pressure within a culture of task orientation.

Returning to the caring chart, while this caring intention seemed to fluctuate with positive and negative external reinforcements, it is clear that when participants accrued more experience and confidence in their own meaning of caring values and priorities, the variations reduced. One participant said, "*Caring is timeless, it is not just a single act. Once you have made the commitment over time and believe that you will be a caring nurse, you will always have it. It might however, fluctuate in intensity from time to time in response to the budget and workload issues. But I believe you can still be caring when it is busy – one shouldn't use that as an excuse. So it has a core and was expressed in various forms and intensity*". Another stated, "*I believe now if it didn't work for this patient, I would try something else, to explore further though it*

might not be easy at times.” Like Henderson’s findings (2001), while participants experienced strong emotions in the context of work, they could consciously use those emotions to refine and improve their practice. This is a high level skill and one which requires great honesty (engage in reflexivity), tenacity and perseverance (firmer beliefs and values with confidence). The participants were able to be more comfortable and were secure with their values through an internal reinforcement. It would be seem as an identity, a nursing identity that is fueled with a belief of caring not only from the head but also from the heart and faith.

The length of time for participants to reach back to its high on the caring chart from its low as a result of a negative reinforcement, be it from the patient’s lack of appreciation or lack of support from the workplace, also vary with participants’ levels of experience and the gravity of the situation. Nonetheless, given the knowledge about caring, it had helped the participants to take shorter time to bounce back, to recover. From an ontological perspective, Watson (1990) has reminded us that caring enables nurses to articulate values, meanings, purposes and direction in nursing. From participants’ accounts, it is evident that nurses want to care for patients and that nurses also need recognition of their care because it motivates them to continue. But others also benefit from less than positive feedback or when the expected didn’t turn out as planned. This learning served as an impetus for some to continue to pursue the meaning of caring from patients’ perspectives. They felt more confident and something they could articulate. Embedded with experience was the personal and professional development as it was illustrated earlier. The personal and the professional are two inseparable aspects. Our findings parallel with those of Henderson (2001) that learning from experience of caring for patients and the understanding of human suffering during illness have contributed to the participants’ personal development and growth.

Caring as a temporal process resonated with all participants that caring in nursing has an “evolutionary meaning” and a “process that changes with time with personal/professional growth”. With maturity and nursing practice experience, there emerged the internalized caring values. The evolving meaning of caring in nursing could be related to the diverse backgrounds and experiences of nurses.

Moreover, some participants began to see time is not the essence for caring and that caring did not entail “big thing”. The followings are illustrative.

One participant said, *“I remember I was on a night shift. A patient who was 80 something, a veteran soldier who had lost both of his legs to diabetes, and had been on our ward for a long time. That night, there was a program about Sino-Japanese war on TV. The old man needed other’s help to relay what had been said on the TV since he was at a distance. I noticed that so I put him on a wheelchair and brought him closer to the TV. Some days later, he was finally discharged home. My colleague gave him a follow-up call and had a conversation. Later she said to me that the old man said you were a good nurse, very sensitive to his need by bringing him closer to the TV set. It was really a small gesture on my part, but it has an impact on the patient. Given my nursing experience and continuous learning about the meaning of caring, if nurses doesn’t work from their heart, patients would easily be blended in with the rest of the surrounding, and we would not see them anymore.”*

Another said, “ I was very happy the day before yesterday when I transferred a female patient to the surgery room for an operation. I could see that she was extremely nervous during the transfer. I held her hand and asked her to relax. I told her that there would be general anesthesia, and she wouldn’t feel anything. It was a simple conversation but she smiled. At that time I realized that I could actually talk to patients during the long way to the operative theatre. The seemingly causal conversation had unexpected meanings to many patients and served to relax them.” This participant also mentioned that it really didn’t take long for someone to care, e.g. it only took a few seconds for her to be responsive to the needs of that patient. And she said, “...the simple gesture reflected my responsiveness to her need at the time, my caring about her.

To care really doesn’t take up more time, if one believes it is part of their work with the patients, and if they also believe the gradual results of this work. Will this then bring out the notion of how one utilizes one’s time? It is perhaps not so much of the quantity when graduates reach a certain level of caring maturity but how does one use it?

Time issue as a nursing perennial problem in caring

As some participants related caring to spending “extra” time in listening to patients given the routine demand, it revealed the concept of time from a quantitative perspective. Hence caring inadvertently would be seen as an added on to their routine practice. It is also clear that the aspects of nursing practice that emphasize on emotion, relationship and caring are not valued in a busy ward within a biomedical culture, it set the learnt priorities for nurses. The evidence based practice also seems to have focused on the best practice that might not have taken patient’s individuality into account. As junior practitioners, they worried about patient safety given a lot of unfamiliar situations that they faced. The time element was also being perceived from a quantitative construct as time management is part of the expected competence from the others of the junior nurses. However, as I reflected upon this quantitative issue of time in relation to participants’ comments about the seemingly incompatibility between physical safety and the psychological care, I was reminded by Watson’s (1985) view that the basic human needs is of spiritual and of which all other physiological needs and safety embedded. Thinking within this context, my questions are: Can’t a fall or restrain-related fall be better prevented if we do “care” about the patient? Or can medication error could be minimized by our “knowing” of the patient as part of one’s meaning of caring?

The importance of theory-enhanced practice

Mitchell (2003) asserts while debates about the role of nursing theory in nursing continued, students’ understanding of the interplay between the abstract theoretical concepts [such as caring] and the particulars that they experienced in practice with patients would expand their understanding of the abstract notion [of caring]. Without the emphasis of this understanding, I join other nursing colleagues in the thoughts that without our own knowledge base nurses will remain at the technical level, driven by the routines and technical tasks. The mechanical view in and of itself is another theoretical abstractions that influence the kind and quality of health care. It is important for nurses to be reflexive and come to understand the choices that they make and

the corresponding reasons within context as professionals. The followings provided an overview.

One participant said, *“This course offered me a new knowledge to support my action and talk with medical doctors. Without this knowledge and hence the confident, it’s very difficult to talk to them.”*

Another indicated, *“From our online discussions, I would be able to put a “label” to my caring action that I wouldn’t have aware of them in the past. I am now better able to construct my practical meaning of caring through the process of learning the abstract theories since I could see how they were brought to life in peer’s sharing through further reflection of our stories in class and through my own practice.”*

One responded, *“I always thought that I was doing great when I had completed the tasks that were expected of me. But after this course, I learnt more about caring and how I would do better at work. Though it seems to be something theoretical, it is quite practical at work if you can actually connect with the patients.”*

Caring as an act and a belief was echoed by this participant as she remembered that one theorist said “any action can be an act of caring”. She continued, “Passing the bedpan can be a caring act. There could be many ways to carry out this task. While everyone could make an observation, but you would have to have such intention that allows you to see what might the patients’ needs be. For instance, in my ward, there was an old woman who was bed bound. After using the bedpan, I noted that she didn’t have a chance to wash her hands. I then started to realize that almost all of the patients weren’t being provided with this basic hygiene. Their hands would not be washed until bed bath. Over the next few days, you could imagine how dirty their hands would become. I noticed this phenomenon from paying attention to our daily living.”

This participant has looked at the patient through her own human self, it is not only about basic hygiene but fundamentally perhaps it is about care of patient’s dignity as a person.

Looking at participants’ caring theories of care in practice, there are interlapping narratives of their reconstructed theories from practice, their personal meanings. Living the assumptions of human science paradigm, we have the capacity for self-awareness. We are basically free beings to make our choices (Watson, 1988), though they would be contextually shaped (Brown 2001). Nonetheless, with the freedom comes responsibility of our choice. Student nurses need to practice reflexivity and to develop personal knowing. As Doane and Varcoe (2005) contended that all practice is theoretical, just as Smith (1992) stated that all knowing is fundamentally and primarily personal knowing. Carper’s (1978) personal knowledge is actually self-knowledge. It involves knowledge of oneself including awareness of one’s values, beliefs, socioenvironmental location to name but just a few. We come to know ourselves through interacting with others, and the significance of our understanding of our growth in caring and its meaning is not fixed. Instead we re-create ourselves through our lived caring moments with our patients. Cultivating self-knowledge enables a clearer view into our making of personal choices of knowing. As Doane and Varcoe (2005) aptly stated that it is part of the process of ‘reflexivity’ that would allow us to expand beyond our own selective interests and to better recognize the taken-for-

granted assumptions and contextual elements that may have limited our view of caring and of the world.

This critical awareness and intentional choice afford an opportunity to better understand the intricate relationships of caring, time and choice. In Milne et al.'s (1996) findings participants experienced tensions associated with spending time. Inadequate time and struggle with time were themes that emerged in relation to spending time as a nursing resource. Students in my study expressed similar tension initially but they were able to map out their reconstructed experience through story sharing and dialogue with each other. It is clear that a supportive culture from peers and administrators coupled with an internalization as organized theory for action with student's awareness are important elements. The linear monochronic (Jones 2001) perspective of time has affected my participants' meanings of time and their time spent in caring. In order to rise above the situation, one needs to ask what does it mean when a nurse said "There was no time for me to talk to the patients". We need to readdress the situation and making the familiar strange. We need to consider our paradigmatic thinking of time.

Conclusion and considerations for future development

As these graduates continued to learn about their growth in caring through narrative pedagogy that emphasizes learning and thinking, using students' experience rather than a cognitive gain, participants' would be encouraged to engage in a thoughtful inquiry into their own experience of caring in practice that facilitated the development of their own personal meanings of caring within a nursing professional context.

While the changes that occurred within some participants might still be revolved around the way to quantify time and task completion, what is significant is their thinking and learning through reflexivity. The reflective self awareness allows the participants to critically consider the personal knowledge and understand its significance in their caring practice through conscious and intentional choices made, even if it is to think of what is possible a little by little. Hence reflexivity is an important underpinning for their continuous growth and to become confident in who they are, what they know, and what they experience (Doane and Varcoe , 2005). Sustainability is facilitated by their personhood, who they are, and what their understanding of nursing and caring is. Participants' caring maturity (cognitive maturity vs. experiential maturity – an expectation of others vs expectation of self) underpins their growth and live in caring. Peer support, role model, a supportive culture of caring is important for their growth during the transitional phase from being new graduates. However, their recognition of the personal development emanated from the professional through reflexivity for personal knowing in the caring process strengthens the sustainability of their caring practice. They came to see their knowledge, confidence and identity from this theory enhanced practice. Hence, there is a need to understand that all practice is theoretical, without it, nursing practice would continue to be unwittingly dictated by routines and tasks without scrutiny.

The revelation of the concept of time offered new possibilities to think of time in caring practice. Ultimately it is not the linear monochronic model of time but how the time is perceived to be

spent depending on graduates' beliefs, values and meaning of caring that would merit further investigations.

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