The nature of nursing: can we teach students how to care?

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Abstract

Caring in nursing is discussed within this paper as the emotional as well as physical engagement of nurses with patients in order to improve their health outcomes and experiences. A critical examination of the literature identifies that caring within nursing has a number of constraints as well as implications for nurses. Nursing ‘care’ can be subject to the driving or restraining forces of social and political change and as this happens, care becomes more or less popular within nurse education curricula. As nurse education has become modular based and teaching to larger and larger cohorts, it could be argued that caring education may become a casualty of these changes. This paper sets out to explore the potential for teaching nurses how to care and discusses the notion of the need for shared beliefs and values and caring for the nurse, in order for the nurse to care for others. A number of potential strategies for teaching care and indeed developing emotional IQ in nurses are discussed.

Key Words

Care, emotional IQ, therapeutic nursing, education, teaching/learning

Introduction

The purpose of this paper is to critically examine the notion of caring in nursing and whether it is something that can be taught to undergraduate student nurses in adult educational settings. The authors argue that caring and its absence are of central importance to nursing as a concept and a professional ideal. The paper critically examines the evidence base, revisiting some of the debates that have taken place in the last two decades concerning the art and science of nursing and the role of caring. The discussion explores the notion and nature of caring, arguing that the caring ethic can be nurtured and developed through nurse education. Our intention is to explore the values and belief systems which underpin nurse teaching and to stimulate debate around these core issues. The paper also raises a number of issues about the consequences of caring and the implications and constraints of emotionally engaging with
patients in contemporary hospital settings. We conclude that nurses can learn about how to
care effectively in small groups by developing their emotional intelligence, learning to
engage with patients, and developing therapeutic relationships. To do this, nurse educators
need to focus more on exploring students' self-awareness through the medium of small group
work. The essence of this style of learning is the development of empathy as a moral
imperative for enabling nurses to focus on the lived experience of the patients and to adopt
interventions likely to become more meaningful than completing a check list of care
procedures that does not relate to what nurses regard as holistic nursing care.

Background

Most writers who try to analyse the nature of nursing describe the essence of nursing as
‘caring’. Caring is something which rises from the ashes of discussion every few years as
health and political situations change and nursing is perceived as losing this essential art.
There was clear hope in the late 1980s and early 1990s for example, that caring, and indeed
‘therapeutic nursing’, was seeing a resurgence almost as a response to the hard-edged and
managerial (as well as victim blaming) approach to health that had developed over the
preceding years.

This resurgence however, was short lived, and in the changing political environment
‘care’ became something that (with a few notable exceptions), was little discussed in the
literature.

Possibly as a response to this change, we are again beginning to see suggestions that
caring is being lost in nursing. Corbin (2008) for example, argues that caring is an art which
is at odds with the conditions under which nurses are working today. Griffiths (2008) in
response to Corbin argues that caring is something that is constantly challenged in nursing
and that it has to be nurtured within each individual.
Brykczyńska (1992) explores the five specific constructs of professional caring identified by Roach (1985); compassion, competence, confidence, conscience and commitment. This helps to separate out the idea of professional caring as being simply an emotive response to someone's distress, or a human response that the majority of people will exhibit. Roach suggests that compassion without competence in nursing is meaningless and this theme is continued throughout most of the literature on caring, i.e. that caring is more than just caring about, it is a distinct professional response to an individual’s need and not something that only professionals recognise. Appleton (1993) in her phenomenological inquiry using individual and group interviews with both patients and experienced nurses identified meta-themes which identified ways of being with clients/patients as important to both patients and nurses. Patients have clearly identified in much of the research the value of caring in nursing. They can ably discern the difference between being treated in a kindly but objective way, compared to being treated in an individual person-centred way (Astedt-Kurki and Haggman-Laitila, 1992; Ersser 1991; Barber, 1989).

The timing of this work is significant as in the late 1980s caring was being discussed as the heart of a therapeutic nursing approach. Meutzel (1988) for example emphasised the intimacy, partnership and reciprocity of the nurse-patient relationship as a therapeutic force. Ersser (1988) emphasised the importance of creating a therapeutic environment and McMahon identified the nurse-patient relationship as fundamental to therapeutic nursing. Muetzel, McMahon and Ersser based their theories on experiences within the Oxford and Burford nursing development units and their experiences could be described as the beginning of an inductive theory which judging from the explosion of writing about these issues within the next few years, many writers agreed was an appropriate area ripe for research. However, the closure of the Burford nurse-led unit, seemed to represent the prevailing politics of the time and the work begun there, did not develop in nursing across the UK.
More recently, authors, though not as prolific, and mostly from the United States, explore the continuous theme of caring. Watson (1997; 1999; 2002) has continued her notable service to the debate on the concept of caring in nursing, labelling it ‘a human science based on a form of humanism’ (2002: 117). A concept analysis on caring by Brilowski (2005) found three important attributes of caring; relationship, action and attitude. Within these, Brilowski identifies that nursing care (action) involves more than just affective issues of caring about someone, but the implicit responsibility to maintain competence and to use nursing presence and therapeutic touch as ways of engaging and communicating with patients to enhance the healing potential. Finfgeld-Connett (2006) had similar findings in her meta-synthesis when she found caring to be an interpersonal process that is characterized by expert nursing, interpersonal sensitivity and intimate relationships. Each of the above is consistent with Wu et al's (2006) research findings which showed caring to have a four factor structure consisting of knowledge and skill, assurance, respectfulness and connectedness.

The consequences of this approach to caring are clarified in the literature by Finfgeld-Connett (2006) who identifies a variety of improvements in both psychological and physical wellbeing in patients/clients. These, it is argued, are partly the result of an increased ability to care for oneself. Brilowski’s (2005) study highlighted the importance of self care and its impact on the patient’s ability for self healing. Well documented publications from the Oxford and Burford Unit (UK) had significantly reduced readmission rates, indicating that patients were more able to grasp the notion of self-care.

The consequences of caring are of obvious importance for nurses and what is of equal importance for educationalists in nursing are the antecedents to caring, as these may help us to explore how caring may or may not be ‘taught’. Antecedents identified by Finfgeld-Connett (2006) include the notion of professional maturity that incorporates competence and knowledge as well as emotional maturity which prevents them from becoming over
emotional (Euswas, 1993) or destructive, controlling or self-centred forms of helping (Montgomery, 1992; 1997).

Other antecedents to caring include moral foundations which involve a commitment to act benevolently to enable caring to be enacted in a conscientious and responsible manner. Interestingly, patient/client openness to caring is identified as an antecedent and this demands that nurses must have the discernment to recognise when a patient’s anger may impede his or her ability to benefit from the sort of relational care discussed in the literature. Overall, the literature suggests that something of the nurse must recognise and value the humanity of all with whom she/he comes into contact as a pre-requisite for caring. However, the antecedents of caring are not all internal nursing attributes. Many writers have indicated that an effective caring environment is one that actively cultivates caring and is supported by shared values in management systems as well as adequate resources such as time. (Schroeder, 1995). The question remains therefore - in our post-modern educational environment, how do we enable nurses to learn caring?

Emotional IQ

Emotional IQ in the context of nursing care, refers to the self-awareness that nurses and others have of the suffering being experienced by the patient and the patient’s family in a given situation. The evidence and much clinical reflection on providing care indicate that the roots of learning to care lie in self-awareness and the development of altruism - a need to share the pain of others. Emotional IQ has been popularized by a number of writers on both sides of the Atlantic notably Goleman (1996), who discusses emotional IQ as the (moral) ability to feel with and for another. Goleman illustrates this as being the notion of caring for others.
He argues that empathy is the opposite of antipathy and requires the empathic person to engage with and feel for others as a moral imperative. A number of writers have attempted to examine what caring means in the context of nursing. Most notably, the philosopher Anne Griffin (1981) has argued that there are different types of caring related to the provision of nursing care which she identified as comprising two broad categories operating on a practical and emotional level. The former enabled the patient to have had all the necessary checks and procedures carried out that would ensure that the pre-planned treatment regimes were carried out according to plan. However, this did not necessarily involve the patients feeling cared for despite all the documentation revealing that care had been given. The second type of care Griffin describes involved the nurse emotionally engaging with the patient and sharing their pain and expressing empathy with the situation. To do this, Griffin argued, requires nurses to develop an altruistic approach based on a form of moderated love for the patient. The empathic nurse however, may not carry out all their clinical procedures correctly and the documentation may not be up to date, but the patient feels cared for because their suffering has been eased and also crucially, because it has been shared.

Constraints to caring

The need for nurses and others to develop a more caring approach to recipients of the NHS is clearly evidenced by the number of complaints received about lack of care, particularly at the end of life (Henry, 2008). Hospitals in the UK, especially areas where acute medical and surgical interventions are required, leave a lot to be desired. Moreover, lack of care associated with long-term conditions (Costello, 2008), older people (Ronning, 2003; HAS, 2000) and the mentally ill (Healthcare Commission, 2008) indicates that the lack of quality care is widespread through many institutional settings. Given this evidence, it is important to recognize and be aware of the many barriers and limitations nurses and others experience
when trying to provide people with individualized care focused on their emotional needs as much as their physical problems. A number of authors highlight the invisibility of the patient when it comes to personalizing care and the lack of individualized care received in hospital from nurses and midwives, who remain disengaged from the patient (Rogers et al., 2000; Rogan-Foy and Timmins & McCabe, 2005; Costa, 2001). Others highlight a lack of proximity, a failure to use touch as a means of communicating and an absence of compassion (Morrall, 2003). In some cases patients complained of being denied information and treated with prejudice because of their ethnicity (Davies and Bath, 2001).

It is clear that many of the problems associated with providing quality care stem from organizational issues, such as lack of time (Mackay, 1993), poor skill mix (Lawler, 1991) and disempowerment on the part of the nurse (Costello, 2004). All of these can, and often do, make practitioners feel as if they have neither the motivation, energy nor skill to provide what the patient needs. Perhaps one of the modern myths about nurses' ability to provide individualized care that acts as a constraint to adequate care, is the nurse's role as a patient's advocate. All too often nurses identify their role as a patient's advocate despite the evidence suggesting that in the context of a modern hospital trust, it is very difficult, if not impossible for advocacy to become a reality (Willard, 1996; Mallik; 1997). The reasons for this are argued to be a fear of stepping out of line, whistle blowing and fracturing the team cohesion by over stepping the mark and speaking out of turn by not following the protocols adopted by the medical ‘firm’ or the nursing hierarchy. Some of the constraints to improving good nurse-patient relations are due to organizational culture determining that the needs of the ward or unit take precedence over those of the patient. Despite the many and varied constraints to developing good communication between patients and their families and professionals, one of the clearest indicators is a lack of confidence stemming from limited education and training in advanced communication skills (Wilkinson et al., 2002).
Developing therapeutic relationships

For many years nursing and nurses have been striving to develop more positive relationships with patients and to improve communications (Wilkinson et al., 1998). Developing therapeutic relationships with patients, whilst obviously involving communication, is not a skill that can be taught in a lecture theatre format. Haggart's (1994) unpublished research identified nurse teachers who felt strongly that they ‘nursed’ their students. This translated as the way that they nurtured relationships with them, interpreted difficult concepts and helped students to put that into practice.

In this way, both teacher and student created a learning (helping) environment in the way that they worked together towards the student's personal growth and professional growth. All of this identified teachers as role modellers. This notion of role modelling relationships and their development is something that Sorrell and Redmond (1997) identify in their research of student nurse narratives.

Their qualitative study identified that students experiencing care from faculty (sic) gain a feeling of belongingness (and value), but also a developing belief in themselves as practitioners. Their findings demonstrate the need to balance rigid rules of student life with an appreciation for the vulnerability of learners, especially those on the threshold of their educational careers.

Indeed there is growing evidence that a nurse's experience can influence their ability to develop effective nurse-patient relationships (e.g. Schroeder, 1995; Ebersole, 1996; Sanford, 2000). This should be recognised within nurse education. Student nurses need to experience therapeutic relationships where they are valued, and interaction occurs which values them as people, where teachers come alongside them as people or professional friends, (not simply because of their label student). This kind of authentic care, based on their humanity, not on a set of external skills or standards, is more likely to strengthen and enable
the student to build these relationships within their own practice (with patients). Mentors, managers and lecturers need to learn how to unleash the human potential of their students.

Teaching and learning about caring

One of the fundamental questions arising from the evidence base related to teaching and learning about care is not whether students can learn how to care, but how educators design teaching and learning situations that facilitate students to learn to care more effectively. This could include learning how to share and utilize their care experiences. In this way educators can capitalize on previous student experiences to help them discover ways of intervening when situations arise where emotional engagement with the patient would be appropriate.

Reflection on practice experiences has become a traditional educational strategy for the last 20 years as a way of helping students develop effective meaning from both their clinical and life experiences. Various models of reflection advocate that practitioners develop their knowledge through reflection, utilizing their clinical experiences to develop and promote different and more enlightened ways of managing difficult situations (Johns, 2002), or tackling problematic clinical issues by learning from and developing insights using different ways of reflecting on practice (Schon, 1987). Both models and other advocates of reflection (Jarvis, 1992; Freshwater, 2002; Taylor, 2006; Ekebergh, 2007) relating to nursing practice, place emphasis on utilizing clinical practice as a means of improving future performance. Taylor identifies different ways of using reflection using the term kitbag of strategies which include art, drawing, poetry, creative music and many others. She highlights technical, practical and emancipatory types of reflection as a way of helping to understand some of the often hidden or deeper meanings behind clinical practice incidents. More recently the debate regarding the use of reflection has turned to consider the use of patient narrative
(Baumann, 2008) as a means of helping nurses to develop ways of caring for patients in a more humanistic way. Baumann (2008: 260) argues that:

Narratives are useful ways to develop understanding of other cultures, families and persons, as well as ourselves. Stories can play a defining role in professional groups. The use of narratives provides students the opportunity to develop their use of imagination, make sense of their actions and gain ability to shift perspective.

Despite the plethora of different approaches to using reflection in nurse education and the value of listening to patients’ stories, it is not always possible to accommodate this type of activity within contemporary nurse education because of curricula restrictions. The organization of educational programmes into modular systems and the large numbers of students involved often influence the development of education which utilizes the power and importance of reflection. Tightly designed modules of study involving large numbers of students limit exploration of students’ experiences in practice and as such constrain the development of a culture of caring. Teachers of nursing have to take the responsibility of identifying ways of helping students of nursing to engage their heart and soul as well as their brain, in their professional practice.

**Conclusion**

This paper has critically reviewed some of the salient literature relating to the concept of caring in nursing. Moreover, the paper has argued that the teaching of caring is a highly significant issue that challenges nurse educators as they and others struggle with public criticism citing uncaring nursing and negative experiences or a lack of care. The authors are aware that what is being proposed is very challenging given some of the constraints to
providing quality care discussed. However, the evidence suggests that there are more examples of poor care within NHS trusts in the UK, than exemplars of excellent care. This remains a major challenge. Evidence also suggests that when people complain about their health service experiences, it is often based on the absence of what people perceive to be good care which is often related to poor communication. The future challenge is to address the issue of caring through the development of robust evidence-based curricula which have caring as a key component. Education at both pre- and post-registration can, and should, play a leading role in helping nurses to become more aware of the power and importance of caring.

Bibliography


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