Learning to engage children:
towards a model for undergraduate students in nursing
- a grounded theory study

This thesis is presented for the degree of Doctor of Philosophy

AUGUST 2000

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To those who welcome the least of these little ones.
Gratitudes:

In completing this study I am most grateful...

To Father God, who has instructed me and taught me in the way I should go. He has counseled me and watched over me. By His grace and to His glory it has been done.

To Professor Rosalie Thompson, who inspired, directed, trained and encouraged me throughout the exploration.

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To colleagues at the Department of Nursing at the University of Cape Town for courage rekindled in corridor-chatter and patience with my sometimes absent presence.

To the Granelli Family Trust, Florence Nightingale Trust and the National Research Foundation Center for financial assistance to complete this work.
Declaration:

I, Minette Coetzee hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise), and that neither the whole work, nor any part has been, is being, or is to be submitted for another degree in this or any other university.

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The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Conclusions arrived at are those of the author and are not necessarily to be attributed to the National Research Foundation.
Abstract

In South Africa, paediatric nursing practice has traditionally been seen as a speciality. Yet in 1998, while a staggering 45% of the population were younger than 18 years, still only 2.4% of all registered nurses held a Paediatric qualification¹ and the reality of the size of the population of children, continued to impact Health Service provision.

The challenge of facilitating undergraduate students learning a traditionally post-basic nursing discipline led to this study in the Department of Nursing at the University of Cape Town. Here the philosophical approach is health based; whole-person orientated and family centred and the programme includes a distinct children’s nursing component. The purpose of the study was to discover how student nurses learn to nurse children. Participants came from four consecutive student groups in their third year of undergraduate study.

The use of grounded theory methodology allowed a rich understanding of the process to emerge. Data included participant observation and student descriptions, both private in reflective journals and narratives and corporate, in focus groups. In the wealth and variation of experience and learning, analysis of data confirmed the complex relational nature of students’ learning. The relationships students establish with the children they encounter in the course of their learning emerged as central to their learning.

Findings indicate that puzzling out connection is the students’ basic social process in learning to nurse children. Students’ experiences of childhood and parenting influence their expectations, interactions and application of learning. The various conditions that affect how students choose to engage children have been extensively explored and described. Students in this study engage children in four distinctive modes; which have been described as playful connecting, dutiful safeguarding, in relay with the child’s mother and distant doing.

The findings of this study contribute to the understanding of how students learn to nurse, especially in the life stage of late adolescence. This is essential for structuring the learning environment and experiences of students learning to care for children.

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Introduction

"Speak gently to the young, for they will have enough to bear; ...pass through this life as best they may, 'tis full of anxious care...."

Shaker prayer

This study is about some of the “young” in South Africa. It is an exploration of how a group of courageous young student nurses continue to puzzle out how to engage and “to speak gently” to the children whom they encounter. For students the most difficult aspect of learning to nurse children, for students is probably the visibility of what many children have “to bear”. Any children who find themselves ‘in care’, outside of family or kin settings have more than enough to bear. It is in settings like these that students in this study encounter children: in day care, convalescent homes and in hospital wards. The added challenge for these young ones, students and children, is that they are living through the changes of a “new South Africa”. This study was undertaken in the transition period after the first democratic elections in 1994. There are probably few places where children have as much to bear, as visibly and with as much “full(ness) of anxious care” as outside of kin or family relationships in a Third World country.

In South Africa, the presence of racial prejudice may be similar to that in many other countries, but what differed here was the systematic implementation of racial discrimination and planned underdevelopment of the majority of its people. In this the children have suffered immeasurably, not only by “…the pervasive violations of apartheid, racial exclusion from most of the land and economy, but discrimination in health care and education have left the majority of children with a historical disadvantage” (Reynolds, 1999: 605). As a newly democratised nation South Africa is still reaping the fruit of more than 50 years of unjust and indiscriminate legislation, governance and social life. Many children have suffered even more as they lived with the dual disadvantage experienced by their mothers especially black women. “Not only did these women have to cope with the common third world problems of poverty and transition from rural to urban situations but, in addition had to cope with the frustration, mistrust and anger that results from unequal distribution of resources of apartheid” (Chalmers, 1990:100).
While resources may now be more evenly distributed, the difficult transitions to urban living persist. It takes more than legislation to heal the memory and experience of severe injustice. It will take some time before the effects of policy changes will be evident and sit comfortably with all South Africans. In this transition time the children can also be seen to reap the benefits of change sooner than others, as legislation and services aimed at children have received more urgent attention. There is no doubt that the changes to the new South Africa have had a profound impact within the country. A visiting psychiatrist from the USA, described it like this: “The amount of social change that has occurred within a brief time has sent social structures reeling and the resilience of the South African people in the face of such enormous change is a testament to their courage and flexibility” (Worthington, 1997:1).

This study has captured some of this courage and flexibility as it traced the actions of real people and children in the processes of learning and of change. The report presents the research undertaken over a four-year period to describe how student nurses learn to nurse children. In this period, a total of 45 students from four successive third-year groups participated in the study. It was set in the context of a four-year undergraduate Bachelor of Nursing programme at the University of Cape Town, South Africa. The purpose of the study was to broaden the understanding of how students, mostly adolescents, learn to nurse children.

A photographer of children describes how his camera offers him “... a way to capture the eyes and catch a glimpse of something of the souls of children...” (Dobson, 1997:iii). The images I have tried to capture for the reader of this study are also glimpses into the souls of young people. The research has been my lens. From the researcher’s vantage point I have often glimpsed the souls of students and sometimes the souls of the children they were encountering in their clinical learning settings. As I walked alongside these young people in my role as teacher, I often saw their determination to work out how to connect or ‘to do’ nursing better. I also saw their exhilaration when they made connections, not only between the theory of nursing and what they had seen or caused to happen in the practice, but more often as they connected with a child. This dual role of teacher and researcher left me in a role not unlike the photographer’s in other ways. The researcher role required me constantly to adjust and focus the lens for accuracy,
while also clearing and filtering the light of my perception in order to see the students more clearly. As I slid, often simultaneously, into the role of teacher, I knew that the camera would also capture glimpses of my soul.

This report is divided into eight chapters. The first chapter gives the reader a context of the study and clarifies the research question by situating it in an initial review of literature. The second chapter presents the methodology utilised in the study. In it the researcher motivates her use of grounded theory and the third chapter presents the reader with the study design. The fourth chapter serves to familiarise the reader with the specific context of this study. It introduces the students, their activities of learning and the clinical settings as well as the teacher. Most of the descriptions in this chapter come from gathered data and are presented to enhance theoretical sensitivity. The fifth chapter presents the reader with the findings of the study and the sixth chapter situates these findings in the current literature. Implications for teaching nursing, nursing practice and theory conclude this report in chapter eight.

A word about voice: The first person has been used extensively in the reporting of this study. The motivation for this is that the researcher wants to remain present in the dialogue. There are, however, different voices to be heard. These include:

- The voice of the researcher, probably the most prominent in reporting a qualitative research study.
- The voice of the teacher, who in this study about the nature of student learning was often part of what was happening and therefore present in student experience. There is also an ongoing conversation between teacher and students as they write their reflective journals as part of their learning.
- The voice of the writer, is an indicator to the reader of the path through the report and is indicated by a directional arrow: ~.

Italics within parenthesis have been used to clarify the words of others and also to indicate the author's emphases. (author's emphasis)

Words indicated with * are defined in the glossary.
CHAPTER 1

The context of learning to nurse children in South Africa
Chapter
The covert
Overenlisting
10 men
children
Some Africans

...
This first chapter introduces the reader to the research. It has been divided into three sections. Firstly, the reader will be introduced to the South African context, including health care provision with an emphasis on the health care of children. This section will include the practice of nurses and their preparation. The second section will explore the literature related to the area of interest as it sets an initial context for the study. The last section will introduce the research question to this context and clarify the significance of the work.

Section 1: The South African context of this study

The political changes in South Africa, which started almost a decade ago, have had a profound impact on the state of health care provision, research and academic training in this country. These changes were secured with the country’s first democratic elections in 1994. The transition of political control within the country has been described as amazingly violence-free (Worthington, 1997: 2). Despite gradual and non-violent change in the government, the infrastructure of the country is being increasingly taxed. This section introduces the reader to the transitioning South African context, between 1994 and 1999, when this study was conducted.

The section will include:

- A brief historical context of health care provision in South Africa, including practices and the changes that have occurred
- Health care of children in South Africa
- Nursing in South Africa: a brief history and the education of nurses
- The undergraduate Bachelor of Nursing programme at the University of Cape Town and the child nursing component in which the research took place.
1.1 Health care provision in South Africa: past and current situation.

‘Apartheid’, or the policies of fifty years of legislated separate development based on race, has left South Africa with two distinct health patterns. The one pattern is that of ‘white’ South Africans that resembles that of most Western industrialised nations. The other pattern of ‘black’ South Africans is similar to third world countries in the rest of Africa and some countries in South America and Asia (Chalmers, 1990:104).

This situation has only barely started changing in the last ten years as the health policies of the previous government, “complex to the point of being unworkable” (Chalmers, 1990:100), are being restructured. The outcomes of the previous health policies were health services, segregated into racial, private and public care systems; ultimately leading to fragmented care. Not only were funds unequally distributed between these health services, but at times as little as 2.3% of the total health budget expenditure was directed towards preventative health care services (Seedat, 1984). This resulted in a good infrastructure for tertiary health care, where services and even innovations comparable with first world countries were performed in the eighties.

International trends in the provision of health care had moved progressively towards Primary Health Care, although probably not as rapidly as anticipated at the Alma Ata Convention in 1978. South Africa adopted the approach in the eighties but the complexity of the established health care structures made change slow and tedious to implement. The newly elected 1994 government was committed to full implementation of the primary health care approach in a new unitary National health care system. Since then changes have been directed towards downscaling tertiary care institutions and redirecting resources to primary care facilities. Service provision has had to move from hospital-based specialist care towards community-based primary health care. While the health sector has undergone many changes, these have been due to this commitment but in the absence of a comprehensive legislative framework (Barron, Strachen, Ijsselmaiden, 1997:xvii).

The terms ‘black’ and ‘white’ are terms that are not easy descriptors of persons and probably terms many people in South Africa today avoid. As many of the country’s citizens search for an identity other than the visible one of skin colour, there are however realities of institutionalised discrimination that are not easy to explain in terms other than these. These terms will be used only in this section to set the South African context of this study. ‘Black’ is used to describe people of traditionally African and/or Asian or of mixed descent. While government policies in the late eighties increased privilege to so called Coloured and Indian people, these groups suffered significantly under government policies and for the purposes of this discussion are included as ‘Black’. ‘White’ is used to describe people of European descent.
In April 1997, the White Paper on the Transformation of the Health System was adopted in South Africa and although this was not a Health Act, a clearer vision for health service changes then emerged. These changes embodied a commitment to accessible health care for all the citizens of the country with particular attention to communities of people who had previously had very limited access. These communities included outlying and rural areas, especially in those previously declared ‘independent homelands*. The following table (figure 1.1) is a summary of the envisaged health service changes (Coetzee, 1998):

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<td>Disease / condition specific units which are hospital based</td>
<td>Comprehensive service inclusive of Health promotion &amp; maintenance; disease prevention; curative and rehabilitation</td>
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Figure 1.1: Envisaged Health Service Changes

These planned changes helps one to see why the then Minister of Health, Dr Nkosozana Zuma, called registered nurses “the backbone of this system”.

Financial resources for health care provision in South Africa stem from two sources - state aided funds and private medical insurance schemes (Chalmers, 1990: 107). Two parallel health services therefore exist in the country. The first is the public health system, which is regulated and funded by a National health budget. This system provides primary, secondary and tertiary level health care to the majority of South African citizens. Cost to the recipients of health care in this system is minimal and if charged, fees are indicated by income. The second system consists of private health practitioners supported by large private hospital groups. These are run as commercial concerns for financial gain, generating competitive levels of health care. Cost of care in these settings is financed largely by medical insurance schemes.
In 1983, 75% of whites and between 5 and 8% of blacks were covered by medical insurance, the white participation in the last 15 years has remained relatively constant while black involvement has increased by 30% (Price in Chalmers, 1990:108). This may be recognised as a glimmer of hope, but still leaves the State with the major responsibility for health care provision. Students in this study worked only in public health settings.

The new government has been determined to make a visible difference to the previously disadvantaged groups in South Africa. Children were one of these groups. Under the apartheid system children were exposed not only to gross human rights violations like detention and shooting (Jacobs and Reynolds, 1986) but also the already mentioned discriminatory health and education practices. The portfolio committee who was developing the country’s new Health Plan in 1993-1994, had suggested that the option of free care at the first point of delivery be considered by the budgetary committee (Jacobs, 2000). In a magnanimous gesture of redress in his acceptance speech just after the 1994 elections, the State President declared that health care of all children under six and pregnant women would from that point onwards be free. The work of the budgetary committee had not yet been done when the President made his speech. The offer thus took both policy makers and public health service providers by surprise and opened the doors of services to an influx of children with common health problems. Attendance at primary level facilities escalated with no equivalent increases of staff or resources (Child Policy Unit, 1999). Health care professionals’ responses have been an example of South Africans’ courageous flexibility described earlier by Worthington.

1.2 Health care of children in South Africa

The first census to cover the re-integrated South Africa was conducted in 1996. The total population was then 37.9 million (Central Statistics Services (CSS), 1997). Age distribution shows a young population with nearly half of the population (45%) younger than 18 years of age. These population statistics justify the assumption that at least half of the health care consumers are infants, children and young people, some of whom are young parents - 13.7% of all babies born are born to teenage mothers (Department of Health, 1998).
The distribution of children by race, age and locale is significant. This is another aspect of the sharp difference between black and white South Africans. Age pyramids show that the black population is much more youthful than that of the white population (Bradshaw, 1997:1). The age distribution of the white population indicates the largest proportion in the age group 20 to 40 years, while in the black population the largest proportion is under the age of 20 years. Bradshaw also points out that the difference between urban and rural dwellers is significant and that there is a preponderance of women and children in the rural areas of the country (1997:1), as men and fathers seek employment in urban settings. In these often under serviced areas unemployment is higher and health services are less available.

This study was set in the Western Cape a province where 86.5% of the population of 4.1 million, lives in urban areas (CSS, 1997). There is, however, a highly mobile sector of the population with movement occurring between rural and urban areas and within poor urban and peri-urban areas. This mobility in the province is particularly affected by two phenomena. The first is availability of contract work on urban and peri-urban construction sites and farms in the area. This occurrence of migrant labour has plagued South Africa through decades of apartheid policies and persists, no longer due to legislation, but because of the consistently high unemployment rates. The second is schooling and later employment opportunities for young mothers in the urban areas. The mobility of parents has meant that families are often disrupted and that the care of children is often undertaken by grandmothers, aunts or elder sisters (Swartz, 1997:6). This author notes that various special household arrangements, child rearing, kinship patterns, and economic structures grew out of the diversity of South African society (1997:5). These factors and the mobility of families all contribute to the health of children in the region and the children encountered by students in this study.

The health of children in South Africa is difficult to extrapolate accurately from infant mortality rates (IMR) as these also differ considerably between the white and black populations. In 1991-1996 the IMR for the white population was 19.3 per 1000 live births compared with 56.1 per 1000 live births of the Black population (SAIRR, 1997). The most recent child mortality rates are from 1990 and were 12.3 per 1000 (Bradshaw, 1997:7).
In South Africa, infectious diseases (36%) and respiratory illness (16%) are leading causes of childhood morbidity in black children under 4 years of age. HIV/AIDS is now the biggest single disease influencing the health of the nation and an estimated 2.4 million people were infected by the end of 1996 (Bradshaw, 1997:110) and AIDS related illnesses in children are rapidly escalating. Antenatal prevalence of HIV is currently the most reliable incidence rate in the country (Department of Health, 1997). While in this province the antenatal HIV rate is still only 1.7%, in provinces further north it is as high as 19 to 25% of all pregnant women.

Childhood injuries associated with violence and accidents are common. In the one to four year age groups, trauma is the highest cause of death among white children (54%). After the age of four, trauma is the major cause of deaths (42% - 51%) among all South Africa children (Yach & Bradshaw, 1995). Poverty, widespread malnutrition and the alternating threat of drought and flood in changing climatic conditions pose increased challenges to health maintenance and care in South Africa. Although not often measured by statistics, disrupted family life has brought unprecedented crises for children of displaced, divorced and single parent families. Economic uncertainty and a significant rise in crime have complicated the transition to democracy in South Africa. Redistribution of resources and restructuring, within every sector of society, have lead to unemployment and further challenges to the health of children. The road has not been a smooth one for South Africans, neither for children nor for adults.

Maternal and child health has been nationally identified as one of the essential components of health care services to be delivered in the context of the primary health care philosophy. This commitment has been confirmed by the establishment of a directorate of Maternal, Child and Women's Health in the National Department of Health and Welfare. Unlike in most other countries, this includes women and mothers as identifiable components in the spectrum of service delivery and “therefore represents a South African innovation” (Jacobs, Wigton, Kakanya & Ngocobo, 1997: 139). Priorities of this directorate include accessible and efficient health services to women and children with a focus on nutrition, infectious diseases, HIV/AIDS and monitoring the growth and development of children.
Although the definition of ‘child’ in the South African legal system varies greatly, health care policies are being formulated in accordance with the United Nations’ convention of the rights of the child that define children as under the age of 18. South Africa ratified this convention in 1995 (Reynolds, 1999:605). An active Child Health Policy Unit has been established at the University of Cape Town’s Child Health Institute. This unit has the brief of actively monitoring all legislative processes to ensure that these are ‘child aware’ and is involved in policy development. Among the most recent policy documents are draft youth and adolescent health policy guidelines, the first in South Africa (Proudlock, 2000).

These are the expectations of the health care system and the work context of registered nurses working with children in this country. Once registered, the nurse may work anywhere in this developing country, rich with diversity and yet still volatile with change.

1.3 Nursing in South Africa: a brief history and the education of nurses

Donahue (1985:2) describes nursing as “the oldest art and the youngest profession”. South Africa boasts the honour of being the first country in the world to attain state registration of nurses and midwives which was legislated in the then Cape Colony in 1891 (Searle, 1991: 75-77). This historic occurrence is largely attributed to the wisdom and perseverance of Sr. Henrietta Stockdale, a British nurse who had undertaken training in London before coming to South Africa in 1874 (Searle, 1965: 137). Sr. Henrietta Stockdale, established a school of nursing in Kimberley in 1877 where she started training local women, thereby initiating the first professional training of nurses in southern Africa (Searle, 1965: 141). She later developed a firm friendship with the visionary nurse leader Mrs Bedford Fenwick, who in the 1880’s was campaigning for state recognition of nurses in the United Kingdom (Searle, 1991:59). Sr. Henrietta Stockdale, also a founder member of the ICN in 1899, was a tireless campaigner for having nursing education vested in higher education and “in so doing to separate the control of nursing education from nursing service” (Thompson, 1988:175).
Despite valiant efforts, this was difficult to establish in the post Anglo-Boer war period, followed only twelve years later by the First World War. National resources were hardly sufficient to maintain hospitals and most nurse teaching was associated with hospitals where “service needs took first priority and students were exploited as a convenient source of inexpensive labour” (Thompson, 1988:175). A hospital-based apprenticeship type training of nurses persisted into the 1940’s when the dire conditions in nursing resulted in discontent and labour action. Despite urgent calls to organise the profession into a trade union, strong opposition finally resulted in proposals for reform and the statutory control of the profession was no longer under the aegis of the South African Medical and Dental Council but under the new South African Nursing Council (Goodchild-Brown, 1990:2). When the Nursing Act No 45 of 1944 was promulgated it provided for the formation of two independent bodies, the South African Nursing Council (SANC) and South Africa Nursing Association (SANA) (Thompson, 1988: 177). SANC protects the interest of the public by regulation of the profession and SANA protects the interests of the profession.

Nurse leaders, especially those involved with education were meanwhile working on proposals for alternative nursing training (Searle, 1991:289). Nursing colleges were proposed to train nurses and to implement the reforms suggested by SANC. In 1937, a Diploma in Nursing Education had been instituted at the University of the Witwatersrand and at the University of Cape Town. The first nursing college, Carinus Nursing College, was opened in Cape Town in 1949 and undertook the basic training of student nurses (Goodchild-Brown, 1990:1). Although the collegiate system placed nursing on a sounder footing, it was only in 1983 that the colleges of nursing became part of the tertiary education system and in 1986 that an association with a university department became obligatory (Thompson, 1988: 179). Despite these developments the funding of nursing colleges remained under the provincial Department of Hospital Services and did not enjoy the autonomy of other tertiary education institutions.

Although SANC recommended that the state finance universities for the establishment of chairs in nursing as early as 1946, this did not happen until much later. The first undergraduate degree was introduced in 1955 (Searle, 1991:294). This was five years prior to the first basic degree offered at the University of Edinburgh in 1960.
This degree was the first in Europe but it came half a century later than the first basic degree offered in the USA, at the University of Minnesota in 1909 (Logan, 1987:7).

Sr. Henrietta had introduced an educational programme based on sound educational principles which not only ensured a thorough integration of theoretical and clinical components but also incorporated community health (Thompson, 1988: 175). The commitment to community nursing especially to children was seen in the certificate courses registered when SANC was established in 1944. Among the original five courses one was a health visitor and school nurse certificate course and another a mothercraft course (Searle, 1991:303).

The continued training of nurses in hospitals however, as well as the technological advances in medicine in the first half of the twentieth century, meant that a community nursing focus was difficult to maintain. Searle (1991: 289) describes that learning while doing in hospital settings meant that it was “often a case of how to do things and not why certain approaches were necessary. Craftsmanship was directed at curative services while preventive and promotive health aspects, for which the hospital authority were not responsible, were neglected entirely”. The establishment of the colleges partly solved this but as funding for nursing training was still vested in each of the four provincial Departments of Hospital Services, students remained in hospital posts rather than receiving the status of students supported by scholarships (Searle, 1991:291). Although students are now considered supernumerary and the educational institution regulates their activities, this situation persists and students are often expected to contribute as members of the work force.

As nurses learned in hospitals the bio-medical model was a dominant influence in nursing practice and often in education. Nursing theory was largely underpinned by the traditions of Nightingale, but in the mid 1960’s the ideas of the North American scholar Virginia Henderson gained respect in South African nursing. This perspective emphasised a human needs approach and offered an internationally acceptable definition of the nurse. Maslow’s theory was also widely adopted by curriculum developers in the mostly hospital-based nursing programmes.
The problem solving ‘nursing process’ within the scientific paradigm started to receive wide acceptance and continues to dominate many nursing programmes and hospital-based approaches and documentation.

The international commitment to *Health for all 2000* had lead to the re-recognition of the role of nurses in the health of people in a country. A 1974 WHO expert committee espoused a shift of the focus of nursing education to community nursing and to a health rather than illness focus (WHO, 1974 and Collière, 1974). It was, however not until the mid-1980’s that nursing curricula evidenced this change of focus internationally. In South Africa discussions among nurse educators culminated in the South African Nursing Council (SANC) publishing regulations for the diploma for the registration as a nurse (general, psychiatric and community) and midwife with a minimum training of four years in 1983 (Thompson, 1988:180). The initial WHO hosted discussions among nurse educators in Britain and Europe culminated in the wide ranging review of educational preparation for nursing, midwifery and health visiting. In the United Kingdom these extensive recommendations were later implemented as a three year programme, *Project 2000* in 1986 (UKCC, 1986).

However, in South Africa health services remained fragmented under the “separate development” policies of the land. Budget investment in Health Care remained inadequate and curative services to individuals and the community largely ignored health promotion. Democratic elections in 1994 brought large-scale policy revisions in South Africa. Health service provision and nursing education were not least affected. The changed philosophical base guiding health provision has made and will continue to make significant demands on nurses, their skills and resources. While some schools of nursing in the country have recently made curricular shifts towards health-based curricula and problem- or community-based models, nursing education at diploma level, remains linked to health service provision. Sr. Henrietta Stockdale’s call at the turn of the last century to separate these may come still closer to enactment with the publication of a new Higher Education Act in 1999. Although legislated, the process of change from nursing colleges within the health sector to full tertiary educational status will require innovative leadership and perseverance.
The new direction in National Health policy and the changing nature of service provision in the country requires different skills and competencies of nurses and therefore a different preparation of nurses. Figure 1.2 indicates these changing requirements.

<table>
<thead>
<tr>
<th>Paradigm: Disease-based approach with hospital care</th>
<th>New paradigm: Primary health care approach with personal, family and community responsibility for health maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors make diagnosis and prescribe treatment, therefore nurses have a more dependent role</td>
<td>Nurses are required to promote health and make clinical diagnoses and decisions concerning treatment and referral.</td>
</tr>
<tr>
<td>Nurses are mostly required to carry out the doctor's instruction</td>
<td>Nurses are required to initiate and supervise care. New skills in managing people (professional, lay and traditional health care workers) are required.</td>
</tr>
<tr>
<td>Delivery of care is task orientated</td>
<td>Continuity of care across settings and over time</td>
</tr>
<tr>
<td>A nurse is the multidisciplinary team co-ordinator in the ward setting</td>
<td>There is collaboration within inter-disciplinary and dispersed inter-sectoral contexts</td>
</tr>
<tr>
<td>The public and family are tolerated with minimal involvement</td>
<td>Nurses collaborate with family members and the public who participate in the delivery and management of care</td>
</tr>
<tr>
<td>Place of work is confined to the unit in the hospital or clinic.</td>
<td>Place of work extends to a context which is closer to more of the people in the community</td>
</tr>
<tr>
<td>Units or wards tend to run on traditions of hierarchy with clear &quot;rules&quot;, with a Human Resources team to deal with problems</td>
<td>Each nurse now requires well-honed relational skills, including team building, negotiating, motivational, facilitation, counselling and networking skills</td>
</tr>
<tr>
<td>Research holds low priority</td>
<td>Research awareness and some research acumen is required to ensure the implementation of research based practice</td>
</tr>
<tr>
<td>Education is contained as the domain of a hospital Nursing Education department</td>
<td>Nurses require skills in facilitating adult learning of staff and clientele</td>
</tr>
</tbody>
</table>

Figure 1.2: Changing Requirements for Registered Nurses
(Coetzee, 1998. Erica Greathead RN, is acknowledged in the refining of this presentation.)

Traditionally the nursing care of children has been seen as a speciality. Only 2.4% of registered nurses in the country hold a post-basic Paediatric qualification (SANC, 1998). Regulations require that the basic comprehensive programmes cover only basic paediatric content. This content includes developmental milestones, common childhood diseases, basic mothercraft, feeding and immunisation. Directives require that 420 of the total of 4000 hours of specified clinical experience be completed in paediatric settings. These minimum requirements are usually accommodated in already full curricula, often in multiple short periods, as these best fit the four-year period of the basic programmes in nursing and midwifery.
This limited preparation often leaves the newly qualified registered nurse ill equipped to deal with the complexities of the nursing care of children. Post-basic education of registered nurses who wish to work with children is often not accessible. Although there are 14 schools of nursing registered to offer the course, only 5 currently accept students. In addition, limited resources restrict student numbers on most of these programmes. Despite valiant efforts in various training institutions, the percentage of registered nurses that hold a post basic paediatric nursing qualification, has decreased from 2.8% in 1994 to 2.4% in 1998. This means that the South African population of children is increasing while the proportion of appropriately equipped nurses is decreasing.

1.4 The Bachelor of Nursing programme at the University of Cape Town

The Bachelor of Nursing at the University of Cape Town (UCT) is one of the fourteen degree programmes offered at universities at the undergraduate level in South Africa. In 1983, under the visionary leadership of Professor Rosalie Thompson, the staff at the UCT Department of Nursing embarked on major curricula changes to the undergraduate programme.

In the political and academic isolation of the 1970’s and 1980’s in South Africa, a stirring of dissatisfaction was being felt in this nursing school at the University of Cape Town (Thompson, 1993). The stirring was not unlike that later described by nurse educators in the USA as “the curriculum revolution” (Tanner, 1990; Allen, 1990 and Bevis & Murray, 1990). Issues of change in nursing perspectives and education had arisen after Alma Ata in 1978 and continued to be the focus of discussions and proposals (WHO, 1986). Nurses in Europe and Britain were also meeting and talking about shifting the focus of nursing education, these are evidenced in reports from the European Conference on Nursing (WHO, 1988) and The Nursing Action Project (WHO, 1991).
Rosalie Thompson had been appointed as the new head of the UCT Department of Nursing in 1983. She describes her excitement as she took the reins of a small school in which the ten year old nursing curriculum was ripe for re-visiting and re-vision (Thompson, 1986). Like nurse scholars in the USA, her clearest sense was that of discomfort, of knowing that there must be more than the paradigm of hard sciences and structured nursing actions. Working with an international nurse consultant, Ms Muriel Skeet, their initial broadened evaluation of final-year student competencies identified among others, relational deficits they had not previously recognised (Skeet & Thompson, 1985). The emphasis and expertise of the graduates lay in the scientific nursing models that focus on disease processes and disease management. Like the nurses working on the revised nursing education programmes for the UK (UKCC, 1986: 46), they realised that the focus had to be on health and “...illness would thus be seen as a deviation from health” (Thompson, 1993:2). The model was called creative nursing. It recognised the nurse’s potential to respond to each person in her care as unique and to respond creatively to the needs that this situation required (Skeet & Thompson, 1985). Excited by their recognition and courageous with vision, Thompson led her team in developing a new curriculum. With health at its core, this curriculum committed to the care of the whole person in the context of her/his family. These changes to a health-based curriculum recognised, not only the inevitable trend in health care provision, but also the fullness and rich tradition of nursing as a discipline.

At the time of implementation, the curriculum was in many aspects unique in nursing education. The UCT Nursing department had pioneered the transition in South Africa towards the paradigm shift espoused by the World Health Organisation in 1974 (WHO, 1974). The shift in emphasis from illness to health and content to process, posed time consuming but rewarding challenges for the learners, both lecturers and students. The Medical School establishment at the time did not welcome the proposed changes but the conviction was carried by courage still evident in staff and graduates of this programme. The programme that has evolved is akin to the ‘caring curricula’ that were developed in the USA after the curriculum revolution. In the United Kingdom similar shifts were later implemented in the Project 2000 curriculum.
Almost ten years later when primary health care was adopted as the national health delivery approach in South Africa, the undergraduate programme was well established as a health-based curriculum and the central premise of the importance of health in service provision had been confirmed. Guided by the premise that "personal growth is a prerequisite for professional growth" (Thompson, 1993), the approach emphasises the developmental aspects of individuals, not only of the people whom nurses encounter as patients, but also of the students and faculty. The health-based approach is grounded by a curriculum based on a specific period of the lifespan (e.g. infancy and childhood) rather than on an area of practice (e.g. general or community nursing) or the often-used systems approach. At each stage of the lifespan, normal growth, development and behaviour are considered and only then the deviations from the normal (Thompson 1993). A focus on family is central to the approach and a key area of student experience throughout the programme.

In order to prepare student nurses adequately for the task of serving the rapidly changing and growing South African population, the four year undergraduate Bachelor of Nursing programme has a strong emphasis on Women's Health (which includes Midwifery) and Child Health. This focus was a feature of subsequent national health policy, described above as the Directorate of Maternal, Child and Women's Health.
1.5 Child Nursing component

The 14-week children's nursing component occurs in the first semester of the third year in the four year curriculum. It follows an introduction to the well woman and the experience of normal pregnancy and is followed by an intensive preparation in the discipline of Midwifery.

The researcher joined the UCT Nursing department in 1990 with the brief to redesign and offer this child nursing component. Although the programme was based in a lifespan approach it also had a strong emphasis on the personal and professional development of students. While it would have been logical to start with birth and proceed to mature age, students' developmental stage necessitated delaying children's nursing to third year. The four year programme was thus structured to flow as described in figure 1.3.

<table>
<thead>
<tr>
<th>First year</th>
<th>Second year</th>
<th>Third year</th>
<th>Fourth year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st semester</td>
<td>Health throughout the lifespan in the context of family – an overview.</td>
<td>The adult – in health, illness and disability (incl: the adult at work) within the context of the family. The care of the adult with conditions requiring medical &amp;/or surgical interventions.</td>
<td>Women's health Child nursing component</td>
</tr>
<tr>
<td>2nd semester</td>
<td>The ill adult in hospital</td>
<td>Midwifery – the pregnant woman and family</td>
<td>Older persons (in health &amp; illness). Management of a clinical setting</td>
</tr>
</tbody>
</table>

Figure 1.3: Overview of the four-year Bachelor of Nursing Programme

The component was therefore re-designed after an initial consultation with a group of paediatric nurses, nurse educators and health care professionals. The content was guided by the South African Nursing Council (SANC) regulations and took cognisance of disease patterns in the Western Cape region and the specific learner needs associated with the various clinical settings. This content had to be presented in the context of the philosophical underpinnings of the UCT Department of Nursing [Attached as Appendix 1].
The content, teaching/learning activities and methods of the Child Nursing component are fully described in Chapter four of this report.

Although a nurse with a paediatric qualification had previously offered this component, my additional eight years of experience of nursing children was probably as important in this position as the paediatric nurse qualification. I had only informal training in the practice of teaching. My experience in the clinical setting was augmented by my own experience as a student. My own philosophical base was similar to that of the UCT Nursing department: I viewed the child as a whole person, I saw them as integrally related to their families and always trying to maintain health. My training in a biomedical/illness-based model, had often limited my ability to practice and teach what I believed. In my clinical experience child health was diagnosed by the absence of disease or noted when the child reached an age related developmental milestone. This seemed to ignore any individual factors. There seemed to be no place in this clinical assessment for temperament, or emotional, social or spiritual indicators. My inexperience as a teacher and these contradictory paradigms may have been an impediment, but the challenges of the task only served to heighten my awareness and level of inquiry and lead to the undertaking of this study.

During my initial two years of teaching, I became well acquainted with the component content and with the four-year curriculum. I was excited and challenged by student responses and insights. Their constant questioning always seemed to be related to the how rather than the what of nursing children.

"How do you persuade a three year old child to drink prescribed medicines?"

or

"How did you calm that fretful infant?"

It soon became obvious that the skills and knowledge base we had emphasised in planning were not fully meeting the students’ learning needs. They needed additional skills. Skills I had certainly never been taught! These included specific interpersonal skills - especially communicating with children and their parents, as well as further knowledge of family functioning and aspects of parenting.
I found myself constantly trying to articulate the practical know-how and expertise I took for granted in the practice setting. The challenge for me was working out how to facilitate students learning the art as well as the science of nursing children.

Nursing children is complex, not least of all because the parents and extended family often require as much attention as the child. It had become evident to me that the process of learning to nurse children required investigation. A clear understanding of what helps and what hinders this process would facilitate my teaching and the students' learning. The research would offer an opportunity to consider afresh how students learn about children and how to care for them.

Section 2: Literature review

The literature was reviewed before starting the study so that previous work could guide or direct the inquiry. Literature was also scanned for different purposes throughout the study. The review that follows is the primary literature search in this qualitative study and is focused on the broad area of concern as suggested by Woods and Catanzaro (1988:135). It is confined to broad topics: the process of learning to nurse and to nurse children.

The literature related to the methodology is reviewed in the next chapter (Chapter two - Methodology).

Research in clinical nursing practice is relatively recent and most of it can be traced to the last two to three decades. Kath Melia reported an analysis of work patterns of student nurses in 1979. This was before students in Scotland became supernumerary in clinical placements. In South Africa a similar situation still exists. Here students carry clinical responsibility while they are employed in student nurse posts. Melia's analysis showed students, and not only registered nurses, performing multi-skilled roles. Students in clinical settings were observed to perform in all four measured domains of the primary task: basic nursing, technical nursing, observing & recording and drug administration at third year level. This would probably be similar in the current South African setting. Melia's examination of the roles, rather than just the tasks of nurses contributed to the way in which the work of nurses is meaningfully studied.
Melia’s subsequent work (1981, 1982, 1983) broadened the understanding of student nurses’ experiences as they work in various clinical settings. She has described particular features of students’ experience in training as related to their transience in clinical settings. This includes students’ sense of “nursing in the dark” (without sufficient information about patients) and their struggle to place themselves as “professionals” in training, while they are required to do so much that could and is as easily done by a less skilled person. These findings have certainly added context to the tasks of students in ward settings. The sociological framework of Melia’s study allowed the reader a glimpse of the social context as well as the students’ personal and emotional milieu. It contributed important questions to the debate about what students learn about nursing from their experience in clinical settings and how students make sense of this as they clarify their perceptions of nursing.

A significant study, conducted by Benner in 1984, explored the experience of registered nurses’ clinical practice and resulted in the identification of 5 stages, from novice to expert in the process of gaining clinical nursing expertise. In addition, Benner identified seven domains of nursing practice. These are helping, teaching-coaching, diagnostic and monitoring, management, therapeutic intervention, ensuring quality and work role confidence (Benner, 1984). Finn, Galligan, Haylor and Kelly (1994) used Benner’s skills acquisition model as the conceptual framework for examining student nurses’ work experience with adults. Their analysis revealed that although students gained experience in all seven of Benner’s domains of practice, there were two additional dimensions, unique to students, namely observing and assisting.

A study of the relationship between learning and work in nursing by Campbell and Jackson, suggested that a curriculum must show students how to cope with “both halves of the nursing reality” (1992:492) - the theory and the practice. These authors suggest that the curriculum must address the fact that care-giving makes practical sense by assisting the student to anticipate the tensions that invariably arise from conditions in the clinical setting. These may include conflicting cultural understanding, staffing limitations and time constraints. It must also show students both the possibilities and the limitations of their actions (1992:494).
As the nature of acquisition of nursing skills is further explored, it is evident that attention needs to focus on how these skills are learned. Redmond and Sorrell (1994) report that at the 1989 National League for Nursing Convention, in Seattle, Washington, USA, a resolution was taken to encourage innovations that study the enhancement of caring practices through teacher/student relationships. These authors suggest that such relationships need to be characterised by co-operation and community building.

This concept of caring practices in students' experience may need to be broader than those between faculty and students. Beck (1992) described caring between nursing students and handicapped children and found that sharing the findings of this study with other students reduced their anxiety about upcoming clinical rotations. No other studies have been found which are related to students' learning to nurse children. There may be similarities in learning to nurse children and adults. Some aspects of students' learning with adults in Melia's study (1982) are familiar and set a useful context for exploring students' experiences with children.

Nursing has borrowed liberally from other disciplines for its theories, conceptual frameworks and methods (Boykin and Schoenhofer, 1991:245). This has been no different in the area of nursing children. For instance, the work of Bowlby (1953) concerning 'maternal deprivation' influenced how the nursing care of children was conceptualised. Understanding of childhood development and behaviour is evident in the field of psychology from the extensive use of the work of theorists like Piaget (1924) and later Erikson (1950), in the field of nursing children. The substance and structure of medical knowledge have constituted a pervasive model for organising nursing knowledge and practice. Children (and adults) are still nursed in orthopaedic and cardiac wards organised around the specialist physician/surgeon's schedule rather than that around the specialised needs of the toddlers or adolescents negotiating their impaired mobility.

Nursing curricula that ensued from the development of nursing as a science in the 1950's were largely based on behaviourist principles in which all forms of knowing rested on objectivity, on the belief that truth exists outside of the person who knows (Chinn & Jacobs, 1987:3).
Shifts in this thinking are most notably found in the work of American educators and scholars of the "curriculum revolution" in the late eighties (Tanner, 1990; Bevis & Murray, 1990; Diekelmann, 1990). In addition, disciplines such as anthropology, sociology and education are examples of other fields of influence as nursing as a discipline has found a place in the social sciences.

In the field of nursing education there has more recently been the recognition that clinical experiences must be broadened beyond hospitals and re-structured to better equip nurses for the challenges of practice (Augspurger & Rieg, 1994). Like the family and community settings in the programme at the UCT Nursing department, other educators have reported curricular innovations, as the context of nursing has become re-focussed to health- rather than illness-based philosophical underpinnings. Among these are authors who report the successful use of community resources during initial paediatric experience. Haussler and Cherry (1993) recommend the use of the community as the primary site for teaching paediatrics. The value of family placement's in learning midwifery and children’s nursing at UCT was reported in 1995 (Coetzee & Clow, 1995). While Streubert (1989) reports the use of a high school setting to augment students’ experience of working with adolescents. The value of school placements was confirmed by placements in pre-school settings to broaden perspectives of students communicating health to this age group also at UCT (Coetzee, 1996). As educators explore different methods, studies report curricular and clinical placement innovations and see the benefit reflected in course evaluations. Improved learning can be measured in this way but the questions of why and how students learn there seem yet unexplored.
Section 3: The research question and significance of this study

The purpose of this study is to explore how undergraduate students learn to nurse children. A descriptive, qualitative research design is used, applying the methodology of grounded theory. This method purposes to understand rather than measure this learning process and is more fully explored in the next chapter.

The research offered an opportunity to consider afresh how students learn about children and about caring for them within the context of the Bachelor of Nursing programme at UCT. Initially the research was directed by the question:

*What helps and hinders B. Nursing students as they learn to nurse children?*

The initial analysis, however, soon yielded results beyond original expectations. The data revealed a complex web of relationships that influence the process of students' learning, indicating a breadth and depth of discovery concerning student learning as they care for children. The work was then submitted to subject experts in South Africa and in the United Kingdom and was broadened to answer what seemed to be the bigger question:

*How do student nurses learn to nurse children?*

The aim of the study is therefore to develop a substantive theory of the process of how students learn to care for children.

Although the direction of the study is clearly related to the practice of education, it is approached from within a nursing paradigm. The philosophical base of the study is congruent with that of the UCT Department of Nursing and the researcher, as has been described in this chapter. Every person, whether student, child, parent or teacher, is considered as an individual relating with a wealth of experience and adding emotional, spiritual and relational aspects to the traditionally intellectual and later social aspects of learning. Learning is therefore understood as a social process as students learn about and within the complexities of caring.
With the main purpose of the study being to understand the process of student learning, discussion of related issues will be included:

- theories of learning as these relate to learning to care for children.
- educational implications for child nursing courses at the undergraduate level

Significance and value of the study

At the outset of this study the 1993 SANC statistics indicated that 2.8% of all registered nurses in South Africa held a post-basic paediatric qualification. The 1998 statistics indicate that there are 2326 registered paediatric nurses on the SANC register and this figure now only constitutes 2.4% of registered nurses in the country. There is little evidence that the nursing care of children receives more than basic coverage in the already loaded curricula of pre-registration diplomas and of most undergraduate degrees. There is therefore no doubt that the need to facilitate more appropriate preparation of nurses at pre-registration level in South Africa is urgent. This is particularly important as students learn to work with children and their parents or families in the current South African climate, where traditional and outdated models of caring for children (particularly the ill child) without families' active involvement are unfortunately still prevalent.

The large proportion of South Africans under the age of 18 further increases the significance of the study and particularly so in a climate of rapid changes in health care and increased demands being made on nurses. Within the changing health-care structures, nurses are continually faced with the challenges of resource constraints while the policy of free health care for children under six years has brought dramatically increased attendance by mothers and children at primary level clinics.

Although the care of children and adolescents within the health care professions has traditionally been seen as a speciality, the desperately inadequate ratio of paediatric trained nurses to child population in South Africa can only be redressed by changing the preparation of all registered nurses. Economics and the distribution of specialists cannot dictate otherwise.
The very basic content and practice requirements stipulated by SANC regulations are likely to result in inadequate attention to this obviously vital field of nursing practice in South Africa. The newly registered nurse is presently at best, ill equipped to deal with the complexities of child health and health care in South Africa. All basic nursing programmes at nursing colleges in South Africa are designed, implemented and evaluated under the auspices of a university nursing department. Because Universities play a key role in nursing education in South Africa and it is appropriate that this study be undertaken within the context of an undergraduate programme such as the Bachelor of Nursing programme at UCT.

Although the nature of the qualitative design may prohibit generalisation, the identified concepts will certainly be useful as students are prepared to nurse children in other settings. Recommendations for curricular design could follow. In a climate of rapid change and increasing need among South African children, student nurses need to be as well prepared as possible. Although not explicit in this investigation, more effective preparation of registered nurses will impact child health and child health care in this country.

A clearer understanding of how students learn to nurse children will also, I believe, be of value to disciplines other than Nursing. A descriptive model which can guide curricular development as well as the undergraduate preparation of other students in the Health Sciences will augment teaching in specific disciplines and form the basis of expanded and integrated teaching programmes in the field of child care.
CHAPTER 2

Methodology: 

a motivation 

for 

grounded 

theory
"Wait, please do that again so that I can see how you do it?"

This student's request became mine as I set out to discover how they were learning, and to understand the process of their learning better. I had to find the best path or method to guide me in discovering how students in this setting learned to nurse children.

This chapter traces the process of searching out and coming to an understanding of the most appropriate methodology for this research process. It asks and attempts to answer the question: "What path will lead me to the destination and give me the best understanding?" This meant further exploring the nature of the research question, the researcher's assumptions and worldview. It also required an exploration of current research paradigms and methods to find the best method as a 'route map'. The process led me to grounded theory.

The chapter has been divided into five sections:

- A method that fits: the nature of the research question, the researcher assumptions and worldview
- Current research paradigms
- Qualitative research as method in the Interpretivist paradigm
- Grounded theory as a qualitative methodology
- Why grounded theory for this study?
Section 1: A method that fits: the nature of the research question, the researcher assumptions and worldview

The previous chapter introduced the reader to the substantive area, the social world of students learning to nurse children, and set the context for the study. In finding a research method, it was important that it would help the researcher to understand the complexities of the question: how do student nurses learn to nurse children in an undergraduate programme in Cape Town in 1994? It had to be a method that could accommodate the complexities of the socio-political and educational setting.

The participants of the study were students. They were young people between the ages of 19 and 21, who would be working with children. The children were invariably encountered in day care, convalescent homes and in hospital wards. Settings where they were in the care of people other than their own kin. These children were mostly compromised in some way: ill, troubled and often without the constant support of their parents.

The learning was occurring in a curriculum that encourages students to question, to reflect on and consider their developing skills and practice. The programme was committed to creating opportunities for students' personal and professional growth. The curriculum, described in the previous chapter, was very unlike those in which other student nurses working in the same health services learn. The health services, like the people in them and in the country, were (and remain) in the early phases of shedding the constrictive but familiar ways of being, which had been entrenched by apartheid.

The registered nurses in the health care settings where students' practical learning happens supervise but rarely give care. They may run the units, but decision making is almost always vested at a level higher than themselves, both nursing and medical. Most of the care settings were characterised by strict hierarchies and patterns of practice established over time, often guided by convenience or habit rather than evidence of efficiency. Resource constraints, including time and material resources, were often held
as reasons for patterns of practice. The changing socio-political structures made any further hint of change threatening. Student learning was therefore occurring among a people who are mostly disadvantaged by the many-faceted nature of poverty which follows institutionalised oppression. This is a poverty of years of struggling and resisting by those seen as oppressed and oppressors: people are poor in resources, poor in memories of good, poor in energy yet often courageous. A people who were not allowed to make decisions, now seem unwilling to act decisively and as before, are unable to trust the decisions which others make. The ideals of faith, hope and love are far from realised for a people living in post-apartheid poverty.

As the teacher guiding these students, I was relatively new to the practice of education. My personal belief in the value of persons, including children, and their important place in families underpinned my nursing care of children and served to guide my educational practice. I saw each person, and therefore each student, as unique and participating in life, learning, caring and getting better at whatever they were doing. These personal beliefs were congruent with the philosophical statements of the team I had joined at the UCT Department of Nursing, which meant congruence for students in their learning throughout the four-year programme.

The area of inquiry was as yet unexplored and the method would thus need to fit this aspect. The researcher, being the teacher, could not stand on the outside or even on the periphery. The role of practitioner-as-researcher would need a research method to accommodate this. A method that would enable the researcher to make sense of her knowledge of the practice while managing and utilising it as a resource in the inquiry.
Section 2: Current research paradigms

In this section the development and construction of nursing knowledge will be considered. The section will consist of the following:

- Current research paradigms
- The research - paradigm fit
- Qualitative research as method in the Interpretivist paradigm
- Grounded theory as a qualitative methodology
  - Grounded theory: definition and methods
  - Grounded theory: its origins in Symbolic Interactionism
  - Grounded theory: critique and discrepancies in application
- Why use grounded theory for this study

2.1 World views in the construction of nursing knowledge

Polit and Hungler (1989) maintain that the purpose of research is to develop, refine and extend the scientific base of knowledge. If it is the purpose of research to generate knowledge, it seems as if the best place to start is at the macro level. In order to gauge the development of knowledge, the frame of reference from within which understanding occurs and meaning is assigned is an important consideration. It is important, not only to the development of knowledge but also to the appropriate evaluation of the outcomes of research endeavours. As my search for a methodological ‘route map’ began, therefore, an overview of current world views or paradigms in the development of knowledge clarified my thinking and direction.

If research is the endeavour of creating knowledge, or, as Szent-Gyorgyi (1980) contends “smooth(ing) out contradiction and mak(ing) things simple, logical and coherent” (cited by Morse, 1994: 1), doing research must depend on how we see things. Nursing knowledge is governed by philosophical viewpoints that describe the nature of human beings and human-environment relationships (Fawcett, 1993: 56).
It is within these viewpoints or paradigms that an observer must ask and approach a question. It is also within the context of a particular paradigm that a question is often answered, unless of course the observations and experience lead the researcher to a shift in understanding and paradigm.

The development of nursing knowledge has been influenced by the paradigms of positivist, interpretive and critical social theory (Lowenberg, 1993:58). Reeves (1996) has described the approaches and belief structures that underpin these three paradigms, especially in the discipline of education, in an accessible and useful manner. A comparison, guided by his description, has been compiled and is presented here as figure 2.1.
<table>
<thead>
<tr>
<th>Positivist</th>
<th>Interpretive</th>
<th>Critical social theory</th>
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<tr>
<td>Analytical - an understanding of reality as mechanistic. It can be analysed and determined. Parts can be separated from the whole to reveal cause and effect relationships between parts.</td>
<td>Constructivist - reflects the belief that humans individually and collectively construct reality.</td>
<td>Critical Theory - these theorists call the quantitative paradigm, reactionary and the qualitative, un-engaged. It is concerned with questions of power, control and theories of knowing (epistemology)</td>
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<td>Empirical - the goal of asking the questions is to define, to predict and to control. Physical phenomena can be explained by experience (induction) and experiments (deduction)</td>
<td>Hermeneutic refers to the interpretation of experience. There is an emphasis on language, history and a commitment to culture. Traced to the Greek word “to interpret”, derived from Hermes, the messenger and interpreter of the gods.</td>
<td>Neo-Marxist - this faction of the paradigm is derived from the “liberation” movements in various disciplines e.g. education.</td>
</tr>
<tr>
<td>Positivist - faith in the scientific process and the perfectibility of mankind</td>
<td>Interpretive - this aspect stresses the need to put analysis in context, presenting the interpretations of many to sometimes competing groups interested in the research outcomes.</td>
<td>Post-modernists - seek to deconstruct the “texts” inherent in the products and programs of society, seeking to reveal contradictions and the exclusion of minority interests.</td>
</tr>
<tr>
<td>Quantitative - reliant on measuring variables and analysing the relationships between these with descriptive and inferential statistics</td>
<td>Qualitative - places the emphasis on the human being as the primary research instrument. This understanding rejects the mathematical modelling of the quantitative paradigm.</td>
<td>Praxis - this aspect represents a desire to abandon the search for truth (by empiricists) and understanding (by interpretivists), in favour of seeking “little truths which are appropriate to the situation.”</td>
</tr>
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The belief is that there is a material reality, which exists apart from beliefs of individuals, groups and societies. Therefore measurement occurs best when the observer or researcher is detached or objective: an objective reality.

Unlike the claims of objectivity and subjectivity of the other paradigms, the proponents of this paradigm carry the “social activist” label with pride.

Figure 2.1: Current Paradigms of thought in research endeavour. (Adapted from Reeves, 1997).
Dreyfus and Dreyfus (1996:30-37) have tracked the origins of positivist thought in a way that contributes valuable insight to this discussion. The relation between theory and practice and between reason and intuition has concerned our culture and way of thinking since it was first defined in ancient Greece. Socrates (born 469 B.C.) in answering the question: "What is the difference between a theory based craft like medicine and skills based on rules of thumb like cooking?", concludes that any craft (later science) must have "principles of actions and reason" (1996:32). This claim that the craft or *techne* must be based on a theory that can be articulated by its practitioners rules out all forms of intuitive expertise. Unable to explain the success of heroes, skilled statesmen and prophets in these terms led Socrates to the reluctant conclusion that no one knew anything! Plato came to his rescue with the suggestion that these experts had learned their non-empirical knowledge, like morality and mathematics, in another life and that they must be assisted by the philosopher to recall them. These principles would ground their skill. Knowledge must be "fastened by the reasoning of cause and effect" and this "is done by recollection". The positivist paradigm - the Platonic rationalist tradition - evolved from these early philosophers and guided the growth of knowledge and theory for centuries. This was, and remains, most successful and appropriate in many of the natural sciences.

**Positivist science** also made a significant contribution to early research and theory development in nursing. Positivism was synonymous with "good science" (Harper and Hartman, 1997:30) and was highly valued in the discovery of medicine’s knowledge base. In an attempt to gain credibility and recognition with medical colleagues much of initial nursing research utilised the methods of this paradigm. However a growing awareness that this paradigm was not an ideal fit, is evident in nursing literature from the 1970’s. The writings of many nurse researchers including Watson (1981); Munhall (1982) and Benner (1984) indicated the need for an approach that could better embody the practice and the discipline of nursing. Boykin and Schoenhofer (1991:245) describe the need for research methods with the potential of "...illuminating rather than obscuring the uniqueness, subtlety and depth of nursing knowledge".
At this point we return to Dreyfus and Dreyfus’ historical track, and pick up a mere one generation after Plato. Aristotle suspected a crucial missing link in Plato’s medical model of knowledge. As he considers the expert, he sees precisely the intuitive response rather than the ability to give reasons. His conclusion is that “...art (techne) does not deliberate”. He is clear that even if there were universal principles based on theory, intuitive skill is needed to see how these apply to each particular case.

As one considers the discomfort described by the nurse researchers who first questioned the appropriateness of the positivist paradigm, these conclusions drawn by Aristotle are certainly interesting to note. Is it this appreciation of intuitive skill and the welcoming of different applications of theory to each case or context that embodied the shift in paradigm from positivist to interpretive in the 1970’s and 1980’s?

The interpretive paradigm assumes that knowledge is socially constructed within a specific historical and cultural setting. It allows the inquirer a place within the process of inquiry, whether that is as an outsider gaining entry (as is often the case in anthropology or sociology) or as an insider (where researchers are also the practitioners). This paradigm shift certainly offered the possibility of illuminating rather than obscuring the subtlety and depth of nursing practice and knowledge.

The critical theory paradigm can also be attributed to a shift in awareness and experience. Benner defines experience as “turning around, adding nuance and a changing of preconceived notions or perceptions” (1996:233). It seems that as researchers paid attention to being part of the research setting in a new way another paradigm shift could occur. The previous two paradigms might have been able to explain or describe phenomena, but have done little to address the unequal power relationships between researcher and subject (Meyer, 1993:1066). Recognising and describing the problems of participants is insufficient within this paradigm and empowerment and change remain the principal purpose. This paradigm requires nurse researchers to be conscious and explicit about the bias and political agendas that may inform their research (Harper and Hartman, 1997:36).
2.2 The researcher—paradigm fit

While looking for a methodology that would fit the research I considered these paradigms in current thinking, realising that I needed to situate the study and myself clearly within this spectrum of understanding. My undergraduate preparation was dominated by the positivist paradigm, especially the understanding of subjects like anatomy, physiology and chemistry. Positivism also pervaded the psychology and sociology in the school which I attended in the early eighties. The basis of nursing care, underpinned by a bio-psycho-social model was positivist. We were taught that nurses made diagnoses related to body systems and planned interventions that were measured by predictable responses. Later, however, my experience in the practice of nursing children introduced me to a systems-thinking approach. I was drawn to literature I would later recognise as being situated within the interpretive paradigm. Initially I was only able to recognise this as the qualitative methodologies, however the breadth of understanding of the paradigm came much more recently. My own philosophical basis took form through the experience of my practice and became more established when I joined the Department of Nursing at UCT, where active involvement with curriculum development meant grappling with models and theories of nursing.

Exploring philosophical paradigms helped me to understand the value and importance of understanding research and nursing knowledge from a philosophical as well as a methodological perspective. It was not until the last years of this study that I engaged the critical theory paradigm. I had always been a conformist, one of the many who grew up and learned about life in a struggle-torn country governed by Apartheid. I had always mistaken feminist theory for misguided anger and was unwilling to consider the theories of Marxism and empowerment for fear of revolution. Revolution had never meant turning around in my vocabulary. It had never been associated with thinking or theory, only the possibility of war in real terms. Engaging such a paradigm was therefore not an option for me even in 1994 as I started this study. My subsequent reading and experience has brought new insight, but at the time the interpretive paradigm held the most promise as I searched for a method for this study.
2.3 Qualitative research as method in the Interpretivist paradigm

As described, the interpretive approaches are seen to have emerged in response to limitations in the positivist paradigm, especially within the human sciences. The recognition of the importance of intuition and context, found in the writings of the philosopher Aristotle, places the origins of this thinking much earlier than most researchers note. It was, however, not until the early seventies that significant numbers of philosophers, theorists and researchers moved to this thinking and called it a paradigm shift.

The philosophical base brought a set of assumptions that underpinned reality within this paradigm (ontology). The shift in thinking, therefore, brought the ontological perspective that would guide the development of an epistemology and the research approaches congruent with a different way of thinking. The recognition and acceptance of intuition and the importance of context still undergird the assumptions of the paradigm with the belief that reality is constructed and the whole is greater than the sum of its parts. Therefore more than a single interpretation of reality is possible and acceptable.

Harper and Hartman (1997:30) have used the writing of various authors to describe the epistemology or the assumptions that underpin knowledge and truth in this paradigm:

- Knowledge is constructed in a social and historical context.
- Theories can be generated from the understanding gained from studies in this tradition, but are not usually tested.
- Theories in this tradition are more open and in process and amenable to change.
- Truth is based on logical fit or practical usefulness of the findings to solving the problems. Acceptance rests on scientific consensus of scholars in the discipline.

These assumptions indicate the need for different methodologies of doing research, as well as specific criteria, which can track the research, process and ensure that the research in this tradition is trustworthy.
Lowenberg (1993:58) notes that there has been further development in various methodologies. Nurse authors however tend who separate the current qualitative methodologies in nursing research into phenomenology, ethnography and grounded theory. Although each of these methodologies has developed from different epistemological bases, their broad ontological underpinnings are similar and this places them within the interpretive paradigm. These approaches all aim to discover meaning and to promote understanding. They all focus on subjectivity and on eliminating distance between the subject and the researcher (Harper and Hartman, 1997:31). Central to all these methodologies is the recognition of the importance of the interpretive processes of the researcher in all research activities. While the hermeneutic (phenomenological) perspectives emphasise language, the symbolic interactionist (including grounded theory) and ethnomethodology approaches stress the importance of context (Lowenberg, 1993:57). Context certainly was important for my study.

Lowenberg (1993) proposes that the traditional classification of interpretive methodologies is restrictive and she offers a more comprehensive classification of methodologies. She traces a major difference between phenomenology and the symbolic interactionist and cultural studies. The latter is then divided between sociological and anthropological studies. Her careful interpretation of the sociological perspectives identifies the gradual shift in methodologies from the individual to an increasingly broad societal focus (1996:60). These are more congruent with the broader philosophy of science and social science views. It would appear that some of the methodological trends she tracks evidence the thinking of the critical theory paradigm. She certainly advocates using broader paradigm perspectives rather than the narrower classification of qualitative and quantitative research methodologies in nursing research.

The methodologies within the interpretive tradition have been utilised extensively by nursing researchers to expand the field of nursing knowledge, especially in the last two decades. This is primarily because these methodologies offer nurse researchers valuable approaches to the understanding of human experience (Baker, Wuest and Stern, 1992:1359). Habermann-Little suggests that this may be due to the recognition that these approaches are “congruent with the values and concerns of nursing” (1991:189).
2.4 Grounded theory as a qualitative methodology

The method from within the interpretive paradigm which seemed to suit the research question best was grounded theory. My first encounter with grounded theory was in coming upon the article *Method slurring- the grounded theory/phenomenology example* (Baker, Wuest and Stern, 1992). This clarified a central tenet of grounded theory for me: Glaser's claim that "...it allows us to discover what is going on". It was clearly different from the questions like, "What is the student's experience?" or "What is the meaning ascribed to learning to nurse children." Strauss and Corbin (1990) describe it as an action oriented method, one that is able to describe what is happening in a social setting.

May (1996) reports that the methodology has particularly captured the interest of many health scientists, but there is also evidence of its use in various other disciplines. Moreover, the methodology has been cited as being particularly suitable for studies where the literature has a scarcity of information on a topic (Simms, 1981:356). It was chosen for this study in order to gain a perspective in an area where important variables have not yet been identified. This paucity of research in the field of learning to nurse in a complex social setting is evident from the initial literature review, and is described in the previous chapter.

The grounded theory approach and methodology will be explored in this section guided by the following components:

- Grounded theory: definitions and methods.
- Grounded theory: origins in symbolic interactionism
- Grounded theory: critique and discrepancies in application
- Why grounded theory was chosen for this study.
2.4.1 Grounded theory: definition and methods

Glaser and Strauss (1967) first described this methodology as an inductive research technique developed for health-related topics. These authors defined grounded theory as "...theory developed from data systematically collected through social research" (Glaser and Strauss, 1967).

The term "grounded" means that the theory developed from the research has its roots, or is "grounded" in the data from which it was derived (Burns and Grove, 1993:68). It is grounded in the experiences of people and it is used in an attempt to develop a theory that has emerged from this actual experience. Theory is defined by Chinn and Kramer (1991) as: "...a creative and rigorous structuring of ideas that project a tentative, purposeful and systematic view of phenomena." Within the interpretive paradigm, researchers who have previously been socialised in the positivist tradition risk slipping into a predictive rather than a descriptive model. Strauss and Corbin (1990:22) maintain that conceptualised data and related concepts form a theoretical rendition of reality: it is accepted that a reality cannot actually be known but is always interpreted. Melia (1982:328), in demonstrating the utility of grounded theory as methodology for nursing research, stresses the meaning of theory building as used by Glaser and Strauss as: "...a strategy for handling data in research providing modes of conceptualisation for describing and explaining." Melia suggests that an inductively developed theoretical framework does not have the extra edge it might have if it could claim a basis in a large, randomly selected sample, but it nevertheless has explanatory powers and qualitative depths which other approaches do not allow (1982:329).

As a method of inquiry grounded theory is therefore oriented to discovery, or the generation of a theory. This includes an interest in perceived time and space as well as the importance of language and textual data (Benoliel, 1996:407). Jezewski (1995:28) confirms this by maintaining that any middle range theory grounded in everyday life situations is context-dependent in application, and dynamic and temporal in design. The focus of analysis in grounded theory is behaviour and questions tend to be focused toward action and process (Strauss and Corbin, 1990:38).
Stern (1980:21) explains that when utilising the grounded theory methodology, the researcher attempts "...to discover dominant processes in the social setting rather than describing the unit under study." She adds that data may be collected from various sources including interviews, observation, documents or a combination of these sources. A central feature of the methodology is the use of a constant comparative method of data gathering and analysis (Glaser and Strauss, 1967). Baker and her colleagues (1991) summarise how grounded theory uses an inductive process to code related data and that categories are identified from these coded data. As categories emerge in analysis, these are used to direct further data collection and categories are then linked to form a tentative conceptual framework. The developing theory is expanded and densified by reduction and selective literature sampling and further sampling from the data may verify the theory and further develop it. Sampling continues until no new data are produced to explain the situation further. This is referred to as saturation (Glaser and Strauss, 1967). Memos are kept throughout to record the theory as it is developed step by step and form the basis of the research report (Corbin, 1986:103).

Annells is one of the authors who has extensively explored the current debate about grounded theory, its methods and the implications for users of the methodology. She maintains that there are broad options for users of the grounded theory, but that it is necessary to realise that there are some essential elements of any grounded theory study (1997b: 176-180). These are:

The fundamental techniques initially identified by Glaser and Strauss (1967):

- theoretical sampling
- constant comparative data analysis
- the need for theoretical sensitivity
- memo writing
- identification of a core category
- the ideal of theoretical saturation
The descriptions of techniques by Strauss and Corbin (1990) have included:

- grounding the theory upon data through data theory interplay
- the making of constant comparisons
- asking theoretically orientated questions
- theoretical coding
- the development of theory

Annells adds Benoliel’s (1996) contribution that a grounded theory study must have data sources from a variety of sources.

This last inclusion to the above list affords recognition to Benoliel’s (1996) contribution to situating grounded theory in the current domain of nursing knowledge. Benoliel places the development of grounded theory in a historical perspective by describing the four decades between 1960 and 1996. She explored knowledge generation through grounded theory in nursing and drew her conclusions from an extensive review of grounded theory research reports in nursing between 1980-1994. Benoliel described the difference between nurse researchers using a “grounded theory approach” and doing “grounded theory research” (1996:412). Noting that nurses seemed “to question through a more narrow lens” (p.414) she identified that grounded theory studies were often not grounded in the epistemological underpinnings of the interactionist tradition.

### 2.4.2 Grounded theory: its origins in symbolic interactionism

Grounded theory is a research methodology based in the symbolic-interactionist school of sociology. Glaser and Strauss’ first work together was the now classic study, *Awareness of Dying*, published in 1965. Their next, *The Discovery of Grounded Theory* (1967) was a motivation for a new method in the academic discipline of sociology, which was then pervaded by positivist functionalist theory. At the time symbolic interactionist theory posed the first real threat to the privileged status of the positivist paradigm in sociology. Grounded theory was presented as a research methodology derived from the assumptions and theoretical underpinnings of symbolic interactionism.

Symbolic interactionism is both a theory about human behaviour and an approach to inquiring about human conduct and group behaviour (Annells, 1996:381).
The basic tenet, which emerged from the work of social psychologist George Herbert Mead, was that the self was defined through social roles (Mead, 1962:225). Herbert Blumer, once one of Mead’s students, refined and extended this notion and introduced the concept *symbolic interactionism* in 1969. The tradition has undergone considerable development in subsequent decades. Denzin (1992), a more recent interactionist notes that this school of thought has been characterised by "strains, tensions and variety". All of the writings in the tradition, however, embody similar theoretical, empirical and ideological biases that permit the construction of an interactionist text. Denzin (1992, xii) describes Blumer's three root assumptions:

- Persons interact towards things on the basis of the meanings the things have for them.
- These meanings arise from the process of social interaction.
- Meanings are modified through an interpretative process, involving self reflective individuals interacting with one another.

Robrecht (1995:170) reports that early research based on these assumptions took the form of field studies. These yielded theoretical explanations of the events under scrutiny but the lack of explicit methodological procedures elicited criticism from the general scientific community. The challenge for those interested in qualitative inquiry was, therefore, to provide more rigorous explanations of their methods.

Although Glaser and Strauss were both sociologists, they came from different schools of thought and training. Barney Glaser was trained in quantitative methods but he "...was drawn to the richness of experience he observed by those engaged in naturalistic field research" (Robrecht, 1995:171). Anselm Strauss was from the Chicago School of Sociology where symbolic interactionist theory had developed; the school also had a history of pioneering qualitative research. In the early 1960's he invited Glaser to join him at the University of California in San Francisco. It was from here that they completed their initial research and publications. Many students, including a sizeable group of nurse scholars, received their doctoral education through the postgraduate courses offered here, where Strauss continued to teach for twenty years (Star, 1997:para 1.2).
After their 1965 and 1967 publications, Strauss and Glaser promoted the use of grounded theory through two major publications. Glaser published *Theoretical sensitivity* in 1978, while Strauss wrote *Qualitative analysis for social scientists*, published in 1987. Both works further explore the methodology and analysis of grounded theory. In 1990 Strauss and a nurse colleague, Juliet Corbin, published *Basics of qualitative research* to assist grounded theorists, especially beginners, to learn to construct in-depth and dense grounded theories in a consistent manner.

As more researchers from different disciplines used the methodology to answer different research questions, philosophical perspectives other than those from the interpretive paradigm influenced its development. Critical theory perspectives have certainly influenced most symbolic interactionist methodological approaches within sociology. Lowenberg (1993:59) points out that this trend is not as evident in nursing research and that grounded theory studies continue to accord less emphasis to both power inequalities and the broad context within which the phenomenon is located.

The original intention of symbolic interactionism was of critical, pragmatic, cultural and interpretative social science. The greatest criticism of symbolic interactionism, like the criticism of the interpretive paradigm seems to be that of irrelevance (Denzin, 1990:xiii). While promising to “tell it as it is”, it appears that symbolic interactionism has more recently had to face the challenge of addressing the unequal power relationships between researcher and subject (Meyer, 1993:1068). Critical theorists believe that theory cannot be written by merely watching, especially if the theory-practice gap is to be narrowed. They have, therefore, aimed to develop social theory in a participatory manner while simultaneously effecting change in the actual setting. The theory-practice gap is a much-debated issue in the nursing practice, research and education literature. The criticism is that the theories generated by traditional qualitative methodologies, like grounded theory, have not come obviously closer to narrowing this theory-practice gap (Lowenberg, 1993:61).
Glaser and Strauss' (1967) original work purposed that grounded theory be utilised in the ahistorical perspective. The "new researcher in the field" scenario Glaser and Strauss then proposed, is no longer often the case and there are more and more practitioners doing research about their own practice. These include nurses, teachers, therapists and others and this increases the challenge of adhering and adapting the specific methodology. This requires careful unpacking and meticulous description of the practitioner's perceptions from experience earned by years in practice. Later interpretations in grounded theory maintain that this is not to be discounted or "bracketed out" as proposed by other qualitative methodologies, but rather to be recognised and woven into the data as it progresses (Chenail and Maione, 1997).

These contributions, criticism and praise, all serve to enrich the current perspectives of grounded theory and will guide the utilisation of this methodology in this study. Initially, the methods and techniques were guided by the writings of Strauss and Corbin (1990). As the analysis progressed, additional writings and researchers in the tradition were further consulted for guidance, including Glaser (1978) and Spradley (1980). Lowenberg (1993: 59) suggests that nurses who have been more thoroughly grounded in symbolic interactionism incorporate more of both the power imbalances and the context in their research. Although I cannot claim to be 'thoroughly prepared' in symbolic interactionism as this was only one theme of my undergraduate major in sociology, both these aspects were key in conducting this study and will be explicitly discussed at various stages in this report.
2.4.3 Grounded theory: critique and discrepancies in application

After the publication of Strauss and Corbin’s text in 1990 an active debate arose among grounded theorists about what constitutes grounded theory. The criticism has been most public in *Basics of grounded theory analysis* (Glaser, 1992). Melia summarises that, what "seemed to be an ongoing process of refinement of strategies for handling data and the development of theory, developed into nothing short of a head on clash between Strauss and Glaser" (1996: 368). Melia (1996) has extensively explored Glaser’s criticism of Strauss and Corbin. Other authors, including Stern (1994), Robrech (1995), Annells, (1996,1997a & b), Benoliel (1996) and Babchuk (1996), have contributed to understanding the essentials of the critique.

Annells’ perspectives are the most useful in explaining the development of grounded theory and the debate which has arisen about its nature (1996, 1997a & b). In her review of the different approaches of Glaser and Strauss, Annells emphasises the importance of recognising that qualitative methods have arisen within a historical context and are thereafter “…susceptible to being modified in the era within which they exist” (Annells, 1997a: 120). Like Benoliel (1996), she placed the development of the grounded theory methodology in its historical context. Annells expounds the development of grounded theory in the ‘five research moments of qualitative research” as proposed by Denzin and Lincoln (1994). She proposes that Strauss and Corbin’s 1990 work arose from the ‘third moment’, which was characterised by “blurred genres as the social sciences moved from autonomy towards interpretive dispersion of genre” (1997a: 122). She suggests that Glaser’s distance from the academic scene isolated him from the contemporary qualitative inquiry debates, while Strauss and Corbin would have been more conscious of and influenced by the intellectual movements as they remained in close contact with the debates and the debaters. This explanation addressed the relevant epistemological issues and Annells urges the reader to “…consider the work in its time” (1997a:122).

Annells (1997a) has identified and compared the different philosophical perspectives between what she calls the classic grounded theory method, and Strauss and Corbin’s method.
Her in-depth exploration of these two methodologies highlights epistemology and ontological issues that I did not recognise in my initial and even subsequent exploration of the method (see Figure 2.2).

<table>
<thead>
<tr>
<th>Ontology</th>
<th>Classic grounded theory method</th>
<th>Strauss and Corbin's grounded theory method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epistemology</td>
<td>Critical realist</td>
<td>Relativist</td>
</tr>
<tr>
<td>Methodology</td>
<td>Modified objectivist</td>
<td>Subjectivist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Methodology Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually a first step in a research hierarchy leading to experimental or survey research for verification</td>
</tr>
<tr>
<td>Construction of a framework for action: localised, provisional and ‘verified’ in the existing data</td>
</tr>
</tbody>
</table>

Figure 2.2: Philosophical perspectives of two grounded theory methods Annells (1997a: 124)

A particular criticism of Strauss and Corbin's method seems to surround the issue of the emergence of theory from data. Glaser (1992) maintained that Strauss and Corbin had developed a new method, which he called “full conceptual description” (in Annells, 1997). The essence of this criticism seems to be the inclusion of the “paradigm model”. The paradigm model is an organising scheme “that connects subcategories of data to a central idea, or phenomenon, to help the researcher think systematically about data and pose questions about how categories relate to each other” (Strauss and Corbin, 1990:99). The criticism is that when this way of thinking is imposed on data, theory is not allowed to emerge but rather is forced into a pre-determined scheme. However, Glaser (1978) has also described schemes that could be used to connect categories of data to one another. Even though he suggested that the eighteen proposed “coding families” could be used systematically to guide connecting categories, the conceptualisation needs to lead the analysis (Kendal, 1999:748).

The issue of emergence remained central in my understanding of the method. This meant that since I really started with no idea of the central phenomenon, my initial question was broad and guided by my interest in a substantive field (students learning to nurse children). I understood that data analysis would allow categories to emerge and from these the most prominent or obviously central category became the core category or phenomenon (Strauss and Corbin, 1990: 116). These authors' well-described coding procedures were designed to be accessible to novice researchers and were very helpful.
I had not read Strauss’s theory of continual permutations. I was familiar with and thus remained committed to symbolic interactionism as the underpinning theoretical base of the methodology.

Another criticism is Strauss and Corbin’s introduction of the conditional matrix as an analytical tool. Classic symbolic interactionism is a micro-sociological theory. It purposed to tackle the individual in society, but does not deal with the larger questions shaping society. Annells reports that Strauss and Corbin’s suggestion that a conditional matrix be applied to the data analysis is a departure from the narrower underpinning of the grounded theory. It ensures that macro-social factors need to be considered as possible conditions influencing social interaction. This perspective brought added relevance to this study as issues of broader social context and power would have been difficult to avoid or ignore.

Understanding the development of grounded theory in a historical context helps a novice researcher to recognise the broader perspective of the debate. It is reassuring to recognise, and have it confirmed by other nurse scholars (Annells, 1997b; Kendall, 1999), that there is a choice of methods. It seems that these authors agree that one approach is not necessarily superior to the other and that the decision on what particular approach to use depends on the nature of the question and the goal of the research.

Stern (1994) maintains that one cannot learn to do grounded theory from a book. However Melia (1996) recorded that working with grounded theory in another country (in my case South Africa), means that in the absence of mentors, one is reliant on the work of the originators of grounded theory. Critique and debate reach publication only some time after the events and still more time elapses before these full texts are accessible in other countries. I had no reason to doubt the text of Strauss and Corbin, as Strauss was one of the originators of the methodology. I chose to work with these authors methods and procedures. I will defend portions of the study design and implementation in the research design.
2.5 Why grounded theory for this study?

As already described, I ‘discovered’ grounded theory in 1994 when I was developing my initial research proposal. I was excited by the apparent fit of the method and read some of the earlier nursing texts, including Melia (1979,1981-1984), Stern (1980) and Chenitz and Swanson (1986). I found the Strauss and Corbin (1990) text particularly accessible and thus embarked on the study feeling justified that I had found the right fit. Although my supervisor directed me to read more widely I was then looking to broaden my understanding of data collection and analysis and read Spradley (1980). It was only after 1997 when I returned to the by then numerous recent grounded theory texts that I realised that issues of implementation as well as authenticity were being debated, especially around Strauss and Corbin’s techniques. The wider critique of the ability of grounded theory to influence change, especially from the critical theorists, may have been new to me at that time, but I could certainly recognise the resonance of the concerns. The resolution of these methodological and theoretical concerns will be revealed to the reader in the research design.

Even in the light of the ongoing debate I would still have chosen the Grounded Theory methodology for this study for the following reasons:

Firstly, the theory is developed with the purpose of understanding the complexity of social processes. Learning to nurse is certainly as a social process. Given my own belief system established in nursing and caring for children, inquiry into learning and the nature of learning to care, the interpretive ontology of grounded theory seems to be the best route to use in an attempt to answer the question: “What is happening as students learn here?”.

Secondly, the specific steps in the process of grounded theory analysis and theory development described by Corbin and Strauss gave much needed structure and it enabled me to think systematically and to recognise complex relationships in the data. In the absence of an accessible mentor in grounded theory, the initial structure was useful. It also would not hamper my considering the subsequent developments in the grounded
theory and symbolic interactionist tradition, including the issues of power and giving attention to describing the context in order to enrich the developing theory.

Thirdly, the participants were students learning with the researcher as teacher, a context traditionally fraught with the complexities of power. It was an advantage that methodological and ethical issues of power were recognised from the outset. My constant awareness of these issues will form a strand of discussion through this report as it influenced methodological and relational decisions throughout the study. As indicated earlier, the ethos of questioning and participation pervades the educational setting in this particular curriculum and was certainly an advantage as I negotiated the research process.

Finally, grounded theory is deemed particularly suitable for nursing studies where the literature has a scarcity of information on a topic (Simms, 1981:356). Despite the fact that it was originally designed for use by an outsider-researcher, therefore requiring negotiated access and extensive theoretical sensitivity, a number of researchers have subsequently used the methodology in the role of practitioner-as-researcher.

There are some aspects of this study which could prompt the reader to wonder why I did not move towards a critical theory or emancipatory research design once I discovered the criticism of the interpretive paradigm early in 1997. The broader post-apartheid South African context, the current status of nursing care of children and the need for adequately prepared child nurse practitioners could all have indicated the choice of a different route. The answer to this question has a number of aspects: The initial research question was: what helps and hinders students as they learn to nurse children? The purpose was that of improving learning. Evaluation of the learning seemed premature, as its nature was, as yet unexplored. Somehow I had not found a comfortable fit with the theories of cognitive learning. The emancipatory theories of Freire (1988) and the social learning theories of Vygotski (1978) may have been more fitting.
There were, however, other aspects to consider: the learners were adolescents, comfortable neither with the methods and theories of pedagogics or adult learning. They had the experience of having been children, but not yet of having or caring for children. They were responsible for their learning, but were afforded unpredictable levels of responsibility in the settings of care. It seemed to me that it was necessary to understand and describe the process of this learning prior to moving to curriculum development and evaluation or changing care with students as more involved participants.

I have, however, experienced the student participants in this study as thoroughly involved. They have diligently written and told their stories as I was trying to understand "what was happening". I know that it was often a relief to them that I was not "watching what they were doing". As I understood a little more, they validated or questioned my observations, often with candid dismissal. It is with confidence that I continue to refer to the students in this study as participants, certainly participants who did sometimes step into the critical social paradigm with me as we negotiated the issues of power and context.

●●●●
CHAPTER 3

Methodology:

the research study design
The sociological and paradigmatic underpinnings of grounded theory have been explored. This chapter will demonstrate how it is practically applied in this study. The particular concerns of trustworthiness and the ethical implications for this study, in which the researcher is also conducting the learning activities, conclude this chapter.

This chapter has thus been divided into two sections:
- The research design
- Concerns of trustworthiness and ethical implications.

Section 1: The research study design

The design of this study is described to place the reader in a position to follow the reasoning and choices I made about the research planning and activities. This will allow the reader to track the research process for the purpose of audit.

I first encountered the methodology of grounded theory when I was pursuing phenomenology as a possible methodology to answer the broad research question of student nurses and their working with children. As I have described, I was excited by the possibilities the method offered and persuaded my supervisor to allow me to follow this route. Her wise decision at that time was the condition that I found a co-supervisor who had recently utilised grounded theory. This advice was certainly congruent with Stern's later writing (1994) in which she insists that a grounded theory study should not be undertaken without an experienced mentor. However, in the South African setting this was not an easy directive. I was only able to find one other researcher with whom I could work and who had used grounded theory as methodology for her PhD research. She was no longer in academic nursing and due to a demanding position in commerce her time was very limited. An added obstacle was that she lived 1500km away! We had access to e-mail between 1998 and 1999, but face to face time was more productive.
Although it was primarily Strauss and Corbin’s 1990 text which guided the data gathering and analysis, the thinking of other authors was incorporated both in the grounded theory (Glaser & Strauss 1967) and symbolic interactionist tradition (Spradley 1980) was incorporated. Strauss and Corbin’s specific methods of analysis enabled systematic thinking and facilitated recognition of complex relationships in the data. The procedural steps used in this study are summarised a format which has been guided by Annells (1997a:125) in Figure 3.1.

### The procedural steps in the design of this study

<table>
<thead>
<tr>
<th>Sampling</th>
<th>Theoretical sampling directed by emerging codes until saturated (Glaser and Strauss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of theoretical sensitivity</td>
<td>Professional and personal experience, literature and the analytical process (Strauss and Corbin)</td>
</tr>
<tr>
<td>Constant comparative data analysis:</td>
<td></td>
</tr>
<tr>
<td>Coding</td>
<td>Open, axial and selective (Strauss and Corbin)</td>
</tr>
<tr>
<td>Memos</td>
<td>Code, theoretical and operational notes (Strauss and Corbin)</td>
</tr>
<tr>
<td>Focus on process</td>
<td>Movement over time of a basic social process (Glaser and Strauss), as well as linking action interaction sequences (Strauss and Corbin)</td>
</tr>
<tr>
<td>Category development</td>
<td>Relevant categories emerge from coding, relationships are validated against data; gaps are recognised and explored until saturation occurs (Strauss and Corbin)</td>
</tr>
<tr>
<td>Core category emergence</td>
<td>Core category emerges as basic social process (Glaser and Strauss) around which other categories were integrated using the paradigm model (Strauss and Corbin)</td>
</tr>
<tr>
<td>Conditional matrix</td>
<td>Allows movement between micro and macro levels of analysis and interpretation (Strauss and Corbin)</td>
</tr>
</tbody>
</table>

Figure 3.1: The procedural steps in this study

The study design of this study explains how these procedures of the grounded theory methodology were implemented in this study. The phases of the research are presented with the research activities of each phase.

- Setting and selection of participants
- Phases of the research
- Data collection
- Analysis of data.

Research design and implementation are difficult to separate while maintaining a full picture of the research process. Some application is therefore included and indicated by: *Application.*
1.1 Setting and selection of participants

The purpose of this study was to explore how undergraduate nursing students learned to nurse children. The setting in which the study occurred has been broadly described as the Bachelor of Nursing programme at the University of Cape Town. As the students and their learning were the focus of inquiry, however, the setting was much broader than the traditional classroom setting. Students' learning occurred in various settings. These were most notably clinical settings, which included hospital settings: both acute and chronic or rehabilitative care settings for children aged between newborn and sixteen years of age. It is not common in South Africa for mothers to remain with their ill children, especially not in long term care settings.

There were additional non-traditional clinical placements:

- day care centres
- schools for children with special needs
- with health care workers in an informal settlement*
- homes for children who require long term care (often for children abandoned as a result of AIDS related illnesses or death in their families).

Formal consent to do the research in any of these settings was only sought if I was going to do participant observation there.

In addition to these clinical placements, each student was placed with a well family expecting a newborn by about midyear, a family where siblings were present. Although students did spend time with these families during the time of this study, their reflections were captured in weekly tutorial groups and there was never any reference to experience from this placement in students' journals. Tutorial groups were not captured as data as they were facilitated by different tutors who were convinced that recording may disturb the dynamics of these groups.

The next chapter, (Chapter four) offers the reader a more extensive overview of the context of this study, the nature of the participating students and the structure of the child nursing component. It includes narratives from student participants to assist the reader to contextualise the study more fully.
Student participants

The participants were third year students registered in the Bachelor of Nursing programme at the University of Cape Town. The child nursing component took place in the first semester of third year. Four consecutive year groups of students participated in the study.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of students</td>
<td>11 students</td>
<td>15 students</td>
<td>21 students</td>
<td>17 students</td>
</tr>
<tr>
<td>Participating students</td>
<td>11 students - Group 1 (G1)</td>
<td>12 students - Group 2 (G2)</td>
<td>10 students - Group 3 (G3)</td>
<td>12 students - Group 4 (G4)</td>
</tr>
</tbody>
</table>

Students were approached to participate at the beginning of the children's nursing component when the purpose and anticipated process of the study was explained. Students were also given a written description of the study and asked to consider participating. They were asked to respond independently, thus preventing students from feeling coerced by peer group pressure.

Munhall (1991:268) stresses the importance of agreement by both researcher and participants concerning what will be done if the focus of study changes during data gathering and collection. This is called process consent and offers the opportunity to change arrangements if necessary. This type of consent aims to encourage mutual participation and perhaps mutual affirmation for the participants and the researcher. The consent to participate included negotiation around the amount of time spent and how data would be stored and later reported. Anonymity and confidentiality of children and units, and accurate portrayal of information were discussed. Agreement was also reached concerning maintaining confidence in reporting data and unanticipated findings, and publishing of findings. Relational ethics described by Flinders (1992) and explored later in this chapter guided this time of negotiating participation with the students.

Although the sample is described as students, the use of grounded theory methodology utilises the process of theoretical sampling rather than subject sampling.
As concepts are the basis of grounded theory analysis, these were identified as the researcher compared incident after incident. Incidents were therefore sampled rather than particular students.

Application: All the students in the 1995 group (G1) agreed to participate after a 'process consent' was negotiated (Munhall, 1991:267). The 1996 group (G2) was not approached at the outset of the module as the initial study required only one student group and was clearly circumscribed. However, as the data analysis at that time had resulted in the study being extended, the 1996 student group was subsequently involved, primarily with the aim of validating data already gathered. Their consent was negotiated after the summative evaluation of the 1996 course, as the researcher/teacher role had not been clarified with this group and it was important that perceptions of coercion to participate be avoided. The 1997 and 1998 student group (G3 & G4) was again approached at the outset of the course and consent was negotiated with individual students in the group. The process consent was used with the previous student group and confirmed

Smaling's opinion (1992) is that sound relationships, characterised by discussion and negotiation, are vital in qualitative research methods. Working out this consent with the students enabled them to participate and negotiate other issues with me in my role as the teacher. I also recognised that as a result of the process consent students seemed more aware of the research process in articles and other texts that we discussed in class. I had made a decision that, after the initial introduction, this research would not be discussed in class time, but students often came to me individually at other times and asked how I was doing with "all the work of research". Students were grateful for the fact that the focus was on what was happening rather than on what individuals were or were not doing.

1.2 Phases of the research

This section describes the process of building a grounded theory - from initially considering what helps and hinders students learning to nurse children towards developing a theory on how undergraduate nursing students learn to engage with children summarised in Figure 3.2.
<table>
<thead>
<tr>
<th>Phase</th>
<th>Research activity</th>
<th>Time period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Research design phase</strong></td>
<td>Review of applicable literature</td>
<td>Sept – Nov 1994</td>
</tr>
<tr>
<td></td>
<td>Writing of proposal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approaching clinical learning institutions</td>
<td>Jan 1995</td>
</tr>
<tr>
<td><strong>Data collection phase</strong></td>
<td>Setting up recording equipment and planning data gathering, management and storage</td>
<td>Feb 1995</td>
</tr>
<tr>
<td></td>
<td>Weekly participant observation sessions</td>
<td>Mar – May 1995</td>
</tr>
<tr>
<td></td>
<td>Weekly reading and capturing of student journals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Researcher journalizing</td>
<td></td>
</tr>
<tr>
<td><strong>Data ordering phase</strong></td>
<td>Chronological sequencing of the data over the initial 14 week period.</td>
<td>Jun-Nov 1995</td>
</tr>
<tr>
<td><strong>Data analysis phase</strong></td>
<td>Overview analysis</td>
<td>Jan – May 1996</td>
</tr>
<tr>
<td></td>
<td>Open coding</td>
<td>While teaching G2</td>
</tr>
<tr>
<td></td>
<td>Axial coding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Theoretical notes</td>
<td>May 1996</td>
</tr>
<tr>
<td></td>
<td>Analytical memos</td>
<td>June-Aug 1996</td>
</tr>
<tr>
<td><strong>The Question re-visited:</strong></td>
<td>At this time analysis had revealed evidence of a rich learning process, beyond the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>initial question of what helps and hinders students to learn. After expert</td>
<td></td>
</tr>
<tr>
<td></td>
<td>consultation a revision was therefore prepared to propose that the study be</td>
<td></td>
</tr>
<tr>
<td></td>
<td>upgraded from MSc to PhD registration.</td>
<td></td>
</tr>
<tr>
<td>REVISIT STEP 5 Gathering data</td>
<td>Gaining access and re-negotiating process consent</td>
<td>Dec 1996-</td>
</tr>
<tr>
<td></td>
<td>Focused and selective observation of student journals, focus groups and in-depth</td>
<td>Jan – May 1997</td>
</tr>
<tr>
<td></td>
<td>interviews</td>
<td>and Mar-May 1998</td>
</tr>
<tr>
<td><strong>Data ordering phase</strong></td>
<td>Ordering of subsequent data.</td>
<td>June-July 1998</td>
</tr>
<tr>
<td><strong>Data analysis phase</strong></td>
<td>Theoretical sensitivity</td>
<td>Aug 1998</td>
</tr>
<tr>
<td></td>
<td>Open coding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Axial coding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective coding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code note and memos</td>
<td></td>
</tr>
<tr>
<td>REVISIT STEP 6 Analysing data</td>
<td>Theoretical sensitivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pertaining to subsequent phases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Open coding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Axial coding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective coding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code note and memos</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 7 Keeping track of the research and analyses process</strong></td>
<td>Literal and theoretical replication across incidences</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 8 Verifying emerging theory</strong></td>
<td>Theoretical saturation</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 9 Reaching closure</strong></td>
<td>Discussion and comparisons with conflicting and similar frameworks</td>
<td>Sept 1998-</td>
</tr>
<tr>
<td><strong>STEP 10 Literature comparison phase</strong></td>
<td>Compiling thesis and finalising the report</td>
<td>Dec 1999</td>
</tr>
<tr>
<td><strong>STEP 11 Writing up</strong></td>
<td></td>
<td>Aug 1999-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aug 2000</td>
</tr>
</tbody>
</table>

Figure 3.2 Phases of the research  (Format adapted from Pandit, 1996).
Although this process is laid out here as a linear process of data gathered from four different student groups it was more like a process of recurrent events. Data was gathered in the first 14-week child nursing component with simultaneous initial data analysis. After this period in the first part of each year, further analysis occurred while keeping track of data analysis with copious memos and theoretical notes. Each respective year group was then approached for the process of refining observation and analysis.

**STEP 1: Initial literature review**

In this study the initial literature review was related to the specific methodology, grounded theory, described in the previous chapter. The methodology was an unfamiliar one for the researcher and thus needed exploration. I also reviewed sufficient relevant nursing and nursing education literature to recognise that there was little work in the area of learning to nurse children. This reading along with my experience and interest helped me to define the substantive interest area.

**STEP 2: Access in the research setting**

Extensive guidance was sought and supervision was provided during this phase of proposal preparation. The proposal was submitted for review and approval by the UCT Ethics and Higher Degrees committee and approval was granted before commencing the study in January 1995.

The research setting was varied and not confined to the classroom nor to only one clinical setting. This posed the challenge of who other than students would need to be approached for consent. The flexible nature of data collection, guided by simultaneous analysis was also considered in negotiating consent from the clinical settings. I had well established relationships with both managers and practitioners in the clinical facilities where students would work during this period. I therefore approach only those facilities in which I would carry out participant observation for consent. I agreed with these managers that in reporting neither the institution, staff nor children would be recognisable. However to avoid depersonalisation I chose to give children pseudonyms in the report. Consent (appendix 2) was granted and facilitated a good relationships for the duration of the study.
These relationships stood me in good stead when the research was later extended and I had to re-negotiate access for another two year period (1997 and 1998). I also worked at carefully maintaining open relationships, which brought support of the research process.

In this phase I gave careful thought to the interplay between my researcher and teacher roles. I needed to ensure fairness to all students whether they chose to participate in the research or not. Therefore I tracked my interactions with all the students. The ethical and practical implications of time with individual students were thoroughly considered and had to be revisited throughout the research process.

Initially, the students were asked to consent to my gathering data from their clinical journals and by participant observation. The process of constant comparative analysis had the potential for these methods of data gathering to be expanded as emerging data required further exploration. This meant that students could be asked to explain or expand their writing in different ways to that originally requested. As previously described, the request for participation and gathering data in different ways was negotiated with students throughout the study using process consent.

\textit{Application:} The consent form was developed with the students prior to commencement of the component. The agreement and written consent incorporated their input, suggestions and ideas. There was opportunity for students to reconsider their participation after they had settled into the course and were able to assess their own workload and commitment. Students are usually able to gauge this four to five weeks after starting this component; further review could take place later if required. Participating students therefore initially signed a consent form (appendix 3) that could be reviewed at any stage. Some students negotiated changes especially in the later stages of data gathering. Most of the students agreed to additional data gathering exercises. Some students preferred not to participate in further focus groups, indicating that this was due to their time constraints. I was reassured by these occasional refusals as this indicated that they felt free to choose.
It seemed that this process of negotiating a collaborative consent did enable students to participate and negotiate; and assist them with their own learning process. Individual students acknowledged some ownership of the project and would ask how it was going or make suggestions about progress. Class discussions referring to other research evidenced an increasing familiarity with theoretical terminology, especially in the qualitative paradigm.

Discussions on data gathering and data analysis which follow, further explore the remaining phases of the research process.

1.3 Data gathering

Data sources in this study were varied and were refined to the development of the study. Initially, in the first two groups (G1 and G2), the data was collected only from student journals and participant observation. As data gathering became more focussed, individual interviews and focus groups were added. In the final phase of verifying the basic social process, students were asked to write narratives of their interactions and relationships with one child. The data gathering process is tabled below in figure 3.3.
The constant comparative analysis method of data gathering and analysis required that data gathering be guided by what emerged from the data. The timing of data gathering was however constrained to the 14 weeks between March and May of each year and while analysis continued during this time additional analysis was also done between these periods. This timing resulted in recurrent phases of data gathering over the four year period. This is graphically represented in figure3.4
Figure 3.4 Graphic representation of the study process

1. Student track from proposal to report

2. Researcher and teacher track from proposal to report

3. Combined research process:
STEP 3, STEP 4 and STEP 5: Data gathering: The following methods were used for gathering data.

© Participant observation

Participant observation is a method of gathering data by observation of the participants in a particular setting in which the researcher participates as a member (Polit & Hungler, 1991:651). These authors describe that the researcher strives to observe and record information within the context, structures and symbols relevant to the group members (1991:323). Spradley (1980:33) describes participant observation as giving the researcher the opportunity to observe the activities of people, the typical characteristics of the social situation and what it feels like to be part of this scene. This method is congruent with grounded theory's theoretical underpinning of symbolic interactionism, as one seeks to understand behaviour in terms of meanings. Strauss and Corbin (1990) describe grounded theory as an action oriented method, so observing actions and interactions complements participant descriptions of their experience.

Data were collected using participant observation during clinical accompaniment of individuals or small groups of students. This meant observing and recording observations, while I worked with the students in clinical settings where they were in direct contact with children as well as in a classroom or other learning settings. Encounters with the students in a group afforded me further opportunity to observe and consider the process of their learning.

© Application: Observed incidents, actions, conversations or other dimensions of the learning process, were spoken into an audio-tape recorder by the researcher as soon after the occurrence as possible and then transcribed. For example:

© As I asked sister in charge for permission to be with her, she gave me a big smile which is quite unusual for this particular registered nurse and said: "Yes, yes. You go, you can be there. She is doing so well, she is doing so well!" I told P8 that, and she was obviously pleased. The cubicle seemed small but was warm and sunny. The bath certainly went very well. In a very comfortable and easy way, she picked the child up; weighed him with confidence; spoke what the child weighed. She said that the child had had a drainage of an abscess... Monday 27-3-95, with Participant P8 in a hospital ward.
This is an example of initial descriptive observation. As the study progressed observation became more focussed. Spradley (1980: 33) describes that after the initial broad descriptive observations and analysis, the research focus becomes clearer and one makes *focussed observations*. Finally after more analysis the researcher is able to make *selective observations*. Although Spradley uses these explanations to describe an ethnographic approach and process, it was found valuable in this study as it describes what one is observing. Focussing of observation is also congruent with the data analysis process of the grounded theory approach and the principle of *constant comparative analysis*. As the analysis directs the data gathering, focused observation occurs in the analysis as well as the data gathering.

**Journals**

The students were familiar with writing reflective journals as part of their course requirements in junior years of the programme. The guidelines for journal writing had been developed in the preceding years to encourage reflective journaling (appendix 4) and were not changed. The activity would now serve a dual purpose, reflective learning for the students and textual data for the purpose of understanding “What was happening as students learned to nurse children.”

Students and researcher were familiar with this practice of a written, and responding, conversation in reflective journaling. This was therefore not seen as an imposition or an addition to normal course requirements. The only difference was that this activity did not carry academic credit in the students’ evaluation process, as it had in previous or subsequent years. The students’ motivation to write, therefore, had to shift from writing to augment their class marks, to writing to enhance learning while contributing to the research data. These data were very rich and the relatively large participation meant that the research process would not be jeopardised if some participants wrote less or less frequently.

**Application:** Students were asked to write about their experiences and reflections on experiences in the clinical setting as well as in the classroom setting. Student journals were submitted weekly on Thursdays and returned to students on Fridays.
The researcher read each student journal in the context of that week's programme and data gathered from participant observation. I often asked questions or affirmed student reflections in the journals before returning them. The purpose of this was to encourage reflection to learn and in addition, to understand their thoughts and observations for the research process. Each journal entry with comments was then photocopied before being returned to the students. An example of an entry follows:

I had a good week. I think I am beginning to enjoy working (here). We had two small babies in our ward. Nazline and "Baby". Nazline is 7 weeks old and "Baby" is four weeks old. They both seem to like being held. They sleep for longer when they are in someone's arms. Nazlie started smiling. One of the sisters was talking to him and he seemed to enjoy that. I liked what she did. I just feel very silly when I try to speak to babies in that language. It doesn't come "naturally" to me.

Teacher: I wonder whether one learns this "language" too, what do you think?

Thursday 23-03-95, Participant 3 while in a hospital ward

**Interviews**

Individual interviews were used only in the last two years of the study. The purpose of these was on focussed data collecting and validating the emerging theory. Events or impressions from the analysis directed the interviews. Interviews were not directed by an interview schedule and could be described as unstructured interviews (Polit and Hungler, 1991:279). They were typically conversational and aimed to help me to understand and clarify, without imposing, the perspectives gained from the analysis to that point. Mostly, the interviewee had written about or experienced a particularly salient emerging category or theme that I wanted to understand better. I would then use this to start the conversation, sometimes reading directly from the journal and asking the student to tell me about this or help me to understand better.

The interviews occurred in a quiet setting chosen by the student, usually one of the smaller rooms in the university nursing department. These interviews were also taped and transcribed verbatim.

**Application** In the first phase of the study, I had not spent time out of class or clinical settings with individual students to avoid perceived favouritism in my teacher role, especially before the 14-week component was complete. I had however found that scheduling interviews after students had completed the course was difficult for two reasons. Firstly, students moved quickly to the next curricular component, Midwifery, and had a full and busy schedule.
Secondly, they then seemed less willing or able to remember the process that they had now considered ‘completed’. It seemed that students were best able to articulate their experience during the 14-week child nursing component.

In the third year (G3) I scheduled individual interviews with one student and another four in the fourth year. Only the one with a student from G3 was scheduled during the 1997 component. This interview was with a student whose experience contributed to her learning in a particular way. Her articulation of how these influenced her learning was vivid in contributing to my understanding of other data.

The last four interviews were with students who were participants from G3 and were then in their fourth year. These students were again working in a paediatric setting, this time as part of a unit management module. Their return to this clinical setting after completion of both their midwifery and mental health modules gave them insights into their learning process beyond the 14 week child nursing module. Each of the students I interviewed also had a particular contribution by virtue of their experience or ability to reflect and articulate their experience.

Focus groups

The purpose of using focus groups in the study was similar to that of interviews: focussed, selective data gathering and verification of the emerging theory. Group interactions often enrich data regarding perceptions and opinions (Carey, 1994:225). Small group discussions are a familiar feature of these students’ learning activities. Their opinions are often sought, so focus groups were an easy way for students to converse. Even though most sources suggest groups between 10 and 15 members (Polit and Hungler, 1991:280), I found 3 to 4 to be an easy number. The students were all familiar with one another so entered into the discussion with ease. Yet I realised that even four participants meant that one was more quiet. I again used direct excerpts from journals or interviews or informal comments to trigger discussion and found that their recognition of ‘peer language’ facilitated my understanding of their meanings.
Like the interviews, focus groups occurred in a smaller venue at the department of nursing or at the nurses' residence. The three focus group interviews were also taped and transcribed. I then added observations and my impressions of the group interaction from notes written as soon as the students had left the venue.

**Narratives**

In the last year of study, 1998, I asked students to write a narrative description of their relationship with a particular child as part of a classroom activity. Unlike a journal entry describing an event this tracked the process of their interaction with one child over time and offered clear verification of the process of engaging children. These narratives often described events that had been key learning experiences for the students. Twelve of the 17 students in this group G4, were study participants and they consented to my using their narratives. The narratives added data that confirmed the emerging process of learning as well as patterns of interacting which previous data did not capture with as much clarity.

**Researcher journal**

The researcher journal became the place for documenting my reflections on my own experience of what was for me a dual process. I wrote my experiences of teaching as well as those of doing the research using the same guidelines as those used by student participants. This journal yielded much of what Rogers and Cowles (1993) describe as the audit trail. It contained insights and impressions about teaching as well as questions about the emerging data. In it, I kept track of questions to ask and reconsider or explore further as the analysis proceeded and theory development became clearer. Along with personal responses, the researcher journal therefore contained contextual documentation, methodological decisions and analytical information. Much of my thinking in the process of this research was made visible in this journal and has been used in writing the report. Many of the ongoing dilemmas surrounding the complexity of the researcher / teacher role emerged here.

**Application :** An example of a ‘teacher entry’ follows:

After the students' requests for ‘concrete facts and some ‘notes for a change’, I had decided to approach respiratory conditions in a lecture style, but I felt as if I was becoming more and more distant...somehow. They were not interacting. Even the ones who I expected to interact were not! Obviously it wasn't an easy learning experience for them. Because they often chose just not to be there.
I found myself wondering halfway through, how this kind of learning could be measured. I saw them sparkle at things I said now and again: sometimes stories or things they recognised but this was not always identifiable. After they'd left the morning session at 12h30, I realised that I'd have to make a plan about the afternoon. We were going to do diarrhoeal disease. I knew that if I had to spend the afternoon speaking, like I had the morning, we would probably end in a similar vein. I wasn't sure we would make 15h30.

Thursday, 30-03-95 after a classroom session

Further examples of all these data sources will be indicated in the findings with the symbols used above. The reader will therefore see more of the application and fruit of these data collection methods utilised in this study.

1.4 Analysis of data

As I have indicated, the grounded theory approach and procedures of data analysis described by Strauss and Corbin (1990) were mostly utilised in this study. A central feature of this analytic approach is "...a general method of comparative analysis" (Glaser and Strauss, 1967:vii); hence the approach is often referred to as the constant comparative method (Strauss and Corbin, 1994:273). In this later publication these authors again stress that in using this methodology the researcher must be committed to this style of extensive interrelated data collecting and analysis. They maintain that this will enable the researcher to strive towards verification of the theory as it is emerging. This explicit mandate to verify that the results of analysis are truly grounded in the data throughout the process means that there is no need to assume that additional verification needs to occur after completion of the study.

The process of this study both helped and hindered this commitment to constant comparative analysis. The limit of a 14-week contact time with each group of participants was an inhibiting and yet also a facilitating factor. Although the time limit allowed only initial analysis with the first group of students' (G1) data, open and axial coding of that data occurred while the second group (G2) were doing the child-nursing component. This helped to clarify that students' processes were similar and data collection from the third group (G3) could then be guided by what had already emerged in analysis.
Selective observation and final verification of what had emerged was obtained while the fourth group (G4) were completing their child-nursing component. The three participants from G3 provided the final verification of the basic social process that had emerged.

[Figure 3.5 can be compared with figure 3.3: The data gathering track, to illustrate this.]

**Data collection →**

![Diagram](attachment:Diagram.png)

Descriptive observation

Focused observation

Selective observation

Analysis: theoretical sensitivity, open and axial coding

Analysis: selective coding & defining the process

Analysis: verifying the process as well as modes of action

**Data analysis →**

Figure 3.5: Data gathering guided by analysis of data and emerging focus

Adapted from Spradley (1980: 34) and Pinkney-Atkinson (1996: 49)

Data analysis will be described as it occurred in the steps of the research process. Even though these are described as distinct analytical processes, they were often alternated in the actual research process.

**STEP 6 - Data analysis**

**Overview analysis:**

In the mode of grounded theory data analysis chosen for this study, it is accepted that the researcher has some familiarity with the field of inquiry and that a degree of theoretical sensitivity therefore already exists. Strauss and Corbin (1990:41) describe theoretical sensitivity as "...a personal quality of the researcher, an awareness of the subtleties of meaning of the data ." They recognise that each researcher enters the field with varying degrees of theoretical sensitivity and even though I was very familiar with both the clinical and teaching settings, I had not noticed student actions as acutely before. I read all the initial data, collected and recorded my impressions.
This served as an overview analysis and increased my familiarity with the area of study.

I had approached a co-analyst to assist me with what Beck calls "inter-subjective agreement" (1992: 363). A graduate of the B Nursing programme at UCT, she had conducted a qualitative research study and had also completed a postgraduate diploma in qualitative research methodology and was willing to assist me with analysis. The data was ordered into sequential weeks, which facilitated flow. She first read all the data to establish some degree of theoretical sensitivity and then read to validate the analysis I had done. She made sure that she could easily recognise the codes I had ascribed to data segments and if she could not easily recognise the ascribed code from the captured data, we removed it. This did sometimes happen when I had carried an impression from the event, which would influence analysis yet the actual data could not justify this. Thus agreement between the researcher and an expert judge was achieved at various phases of data analysis. This step of peer review called member check by the Guba and Lincoln (1981), also highlighted the potential for the data to be audited.

**Application** In this study this overview was the co-analyst’s first encounter with the data. We both read all the data and independently captured our impressions in telegraph form. For example:

1st clinical exposure-Educare centre*
Students uncertainty, ill-equipped, lack of relational skills, discomfort, reticence to get involved-asking how to?
One student "knowing it all"-distancing others
Interactions based on adult concerns ("stop" "don't go there") - protecting rather than facilitating/allowing. First concern safety
"clicking" with the familiar and easy to relate to.
What makes a student go to/interact with a particular child or children?

Reading all the data together gave me a picture of the whole process. I had underestimated the complexity of the dual role of teacher/researcher in my planning and found that I had to reschedule time after completion of the initial data gathering phase to devote to further analysis.
Open coding

Open coding was the process of breaking down, examining, comparing, conceptualising and categorising data (Strauss and Corbin 1990:61). In open coding, data were subjected to line by line analysis. Codes were assigned to related pieces of data by subjecting the data to the two basic principles of analysis in this tradition: making comparisons and asking questions. This is the origin of the methodology's description as the 'constant comparative analysis methodology'.

Strauss and Corbin explain that this fractures the data and allows one to identify some categories and their properties and dimensions. This breaking up of data has been criticised by Glaser (in Melia 1996) as resulting in losing meaning. For me the process did seem to merely splinter the data initially. It was however an invigorating process that generated an exciting volume of initial information and understanding. The 'breaking up' in the line-by-line analysis and then reassembling the resultant codes, allowed me to see meanings I had not recognised before.

The co-analyst did not know any of the students and was not involved with the process of teaching or data-gathering. This enabled her to facilitate the balance between the creativity and the science as described by Corbin and Strauss (1990:44). She was able to step back more easily to ask the question: "What is happening here?" and was able to maintain an attitude of scepticism as she examined the data and analysis.

Application: Both researcher and co-analyst did line-by-line analysis of data from each weeks using a software programme called Ethnograph®. In this phase of open coding all the data was assigned codes. After fracturing the data, however, codes could soon be grouped with more meaning. An example of the results of open coding follows:

Initial codes (6 of the 108 yielded): Student non-committal Student attach
Student unable Student play
Student care Student contradict

These were all grouped, eventually, along with a number of others into Student response to child - (1 of 27).
Some of the dimensions of this were:

- easy → difficult
- near → distance
- play→ protect
Axial coding

Axial coding is the step in Strauss and Corbin’s the coding process that has met with a great deal of criticism. I was looking at actions and this coding process suited my data well. I used it as an organising structure, which assisted me conceptually to “see” the relationships between the many emerging subcategories in the data. It enabled me to group codes together so that categories could be identified. The categories served to explain the data and were used to direct further data collection. Concepts were identified as the researcher compared incident after incident, while asking the question, “what is happening?” of the data.

The concepts were identified as they constantly recurred or were obviously absent from the data. As the initial open coding procedure progressed, concepts soon gained the status of categories until the basic social process was identified. The analysis aimed to identify what had given rise to an action, as well as what impact and consequences actions had. The questions and comparisons that arose during analysis therefore guided the sampling, termed theoretical sampling. This helped the researcher to discover additional categories and relate them to one another. Corbin and Strauss (1990:178) maintain that this sampling procedure is cumulative as it increases the depth of focus. The work of Spradley (1980) regarding participant observation was helpful in clarifying and directing the nature of observation in data collection at various stages of analysis.

In axial coding the focus is to specify a category or phenomenon - a central idea, event or happening in terms of the paradigm model (Strauss and Corbin, 1990:110). A broader understanding is then sought by questioning what set of actions or interactions are directed at managing or handling the event. The other conditions that give rise to the event; the context in which it occurs and is embedded and the other factors that influence it are explored. The action/interactional strategies also have consequences that must be identified from the data. In summary: The phenomenon that has emerged as central is identified. Then the data is questioned to find the causal conditions, the contextual conditions, intervening conditions, the actions/interactional strategies and the consequences of these actions on the phenomenon.
Although the researcher engaged in analysis simply alternates between the two, open and axial coding are separate and distinct analytical procedures. Strauss and Corbin maintain that it is important to recognise what you are doing procedurally so that you can do it purposefully (1990:110). Their text reminded me that in developing a grounded theory I was trying to capture as much of the complexity and movement in the real world as is possible. So the discovery and specification of both the differences and similarities among and within categories, were crucial and at the heart of grounded theory (Strauss and Corbin, 1990:111).

Application: As the co-analyst and I started re-organising the data using the paradigm model we made connections between open codes and sub-categories. Clear categories started emerging. After analysing data from the first two weeks we recognised that making comparisons and asking questions helped to give the emerging categories their precision and specificity. Strauss and Corbin’s description of a category as a conceptual name for a phenomenon, a happening or event, is very useful. We returned to data ready to identify categories from the coded form. These soon became evident. One of the earliest of the nine eventual categories to emerge was called: ‘student workout’. This category was described as “a group of concepts related to a similar happening or occurrence of learning”. Applying the paradigm model to this meant searching the data, or returning to data collection to find out in what context this particular event happened. What influenced, helped or hindered students in it? What caused students to work something out? How did they do it? What were the consequences for them of doing it?

Selective coding

This last coding procedure only occurred after working with the third group of students (G3). It is the process of selecting the core category and systematically relating it to the other categories (Strauss and Corbin, 1990:116). The relationships between categories also needed to be validated in the data and the field, as they were further refined. In this phase I moved from description to conceptualisation. In addition I needed to determine which of the nine categories was the core category.
After much deliberation over the data as well as focussed observation in the field, it was clear that the basic social process was a combination of two apparent core categories. *Student workout* and *being with ill child*, were combined into the basic social process called *puzzling out connection*.

This was verified many times and especially helped by Spradley's (1980:33) concept of selective observation. It allowed the researcher's lens to become sufficiently focussed to validate the relationships between the concepts and to clarify the development of the basic social process. The students' action and interaction strategies were clarified and validated in this phase.

**The conditional matrix**: This is the other analytical tool used by Strauss and Corbin to denote a complex web of interrelated conditions, actions/interactions and consequences that pertain to a specific phenomenon. “The conditional matrix opens the analysis to a wide variety of possible conditions that bear upon the given phenomenon” (Strauss and Corbin, 1990:164). This tool is applied to the phenomenon to enable the researcher to consider the broader social context, it was applied in the final stages of analysis. An attempt at describing the different levels of conditions that influence student nurses as they learn to nurse children is attached as Appendix 5.

Chapter five presents the reader with a detailed application of the coding process.

**STEP 7: Keeping track**

Notes were kept throughout the study period to ensure that the researcher could keep track of decisions, and to add to the rigour of the methodology. In their mode of grounded theory analysis Strauss and Corbin specify three types of memos: code, theoretical and operational notes. In this study these constituted the audit trail and were important to keep throughout, thus enhancing its truth-value. As described, my extensive researcher journal contained most of this tracking process. Code notes however were kept separately as the computer programme I initially used had a facility for writing and sorting these.
The theoretical and field notes were first written in my journal as this was my field resource. These were later extracted and used to track and guide analysis.

**Code notes:** These are memos containing the actual products of the three types of coding. These included conceptual labels, descriptions of the assigned code, paradigm features and notes on process. The useful feature of the computer-based programme I used initially was that it cued the researcher to add a note every time a new code or description was added. This was good training for when this programme was no longer sufficient to manage the complexity of data. After I had abandoned the programme after doing line-by-line analysis, I devised further templates myself.

**Theoretical notes:** These were written to keep track of the thinking around the relevant and potentially relevant categories. These included the properties, dimensions, relationships and variations. Strauss and Corbin (1990:197) call them “theoretically sensitising and summarising memos”. In addition to those in my journal these memos were captured on weekly summary sheets especially when I was in a data-gathering phase with the students.

Theoretical notes enabled me to keep track of and guide the process of analysis. It was in these notes that I noted the occurrence of significant insights and data. Here I also tracked data that did not obviously fit in the emerging categories and formulated questions that indicated the need for further inquiry.

As more data were gathered, themes became more varied and it was difficult to keep to the summary sheets. As themes emerged which were broadening the enquiry, I reformatted the matrix of cues initially used in the weekly analysis summary sheets. These often contained themes that seemed to be enhancing the nature of the work while they also often clouded the question. The schema for recording the initial analysis was therefore refined to contain three main themes:

- Research process
- What is happening?
- Teacher role and decisions
The first question could therefore be distilled from the summary sheet and used as operational notes. The second question was the essential analytical question “What is happening?” and contributed to theoretical notes. The third helped me to sift my teacher reflections and insights from the research track.

Operational notes: These were written to keep track of decisions and directions regarding sampling, questions and possible comparisons or leads to follow as analysis progressed. They also included notes on the concepts that I needed to explore further with students.
Section 2: Concerns of trustworthiness and ethical implications

"To teach is to create a space where obedience to truth is practised"

(Palmer 1983: 69)

Likewise to conduct research of this nature is also to practise obedience to truth. Like Palmer, I am using the word ‘truth’ to describe a virtue. In the Interpretivist paradigm what Palmer calls the “rule of truth” (1983:88) is more often called truth value or veracity. He explains that “truth is fidelity rather than conformity. .... Conformity obligates from the outside while fidelity obligates from the within” (1983:90). A commitment to this truth must pervade the research process to enhance the value and authenticity of the study. In this study the dual, often simultaneous and interlaced role of researcher and teacher was a central theme. It was in conversation between these roles that the questions of commitment, authenticity and integrity and purpose arose. These questions offer a way in which to answer the question of how this study could be ethically and skilfully completed.

In this last section I would like to consider the question of ethical and skilful completion of this study. This includes an exploration of the researchers’ responsibility in the study, the ethical guidelines applicable for a study of this kind and the elements required to enhance the truth value or trustworthiness of the results yielded. These will be discussed under the following headings:

- The researcher’s responsibility and commitment
- The issue of ethical comportment and trustworthiness.

2.1 The researcher’s responsibility and commitment

Early in this research process, I was walking along one of Cape Town’s many long sandy beaches. I was walking, as I usually do, on the edge of the water breaking onto the sand.
I was toying with whether to venture into the cold of the Atlantic breakers or stay safely on the firm sand just there beyond where they break. I had been thinking about how I would manage to appropriately add the unfamiliar role of researcher to my comfortable five year role of teacher.

Later I wrote in my journal:

- The teacher/researcher walk may be like this for me. The firm ground is close to the breakers. There is an option to walk in the water as it approaches or to avoid the wave. Sometimes the water feels good, the appropriate place to set your next step and sometimes it is the very place to avoid. It will have to be about choosing when to walk where, choosing where to be and when.

The concerns of trustworthiness and the ethical implications for a study in which the researcher is also the principal teacher of the participating students, are of great importance in this study. My concerns were mostly about how I was going to negotiate these roles well.

Chenail and Maione (1997:2) note that qualitative research in applied fields like education, psychology and nursing has resulted in an increase in the number of practitioners-as-researchers. Access to the research setting may be easier for these researchers, but they have to consider more carefully how they will manage their new role and previously acquired knowledge. Strauss and Corbin (1994:274) maintain that in grounded theory, richness in concept development rests on a great familiarity with data and the setting. Chenail and Maione (1997:13) suggest that the researcher must still face her previous constructions so that her revelations in the process may be scrutinised, challenged and then woven into what they call the sense-making process. This call for an increased awareness and contribution to the research process is similar to Strauss and Corbin's perspective that the grounded theorist takes responsibility for the interpretative role as it is not enough merely to report (1994:274).

Strauss and Corbin (1994) maintain that the theory doesn't exist as separate, waiting there to emerge but that the observer sees it from her perspective. Annells (1997a: 124) concludes that the researcher and the researched co-create theory rather than it emerging.
This does not undermine the value of the work as grounded in the data: instead it emphasises the importance of the researcher's commitment to verify the emerging theory consistently by returning to the data and the participants. Verification is not seeking the process or theory but rather, looking for supporting of findings (Annells, 1997a: 125). The researcher therefore also needs to take responsibility for this role of interpreter.

The researcher is also affected by being with participants who may not only be incidentally contributing their ideas and perspectives (Strauss and Corbin 1994). In this study, students were certainly not 'incidentally contributing', but rather intensely experiencing the process at the time. In the role of teacher, I was usually aware of what affected my own and the students' responses and was familiar with the role of supporting and coming alongside students. In the researcher role, however, I would need to observe more astutely and I came to realise that even if I could interpret responses I would sometimes have to contend with not understanding completely as the researcher, when as teacher, questioning would have been intrusive. Bachelor and Briggs (1994:950) note that the needs and expectations of the researcher and the participants may be different. These needs may be conflicting and there is then the possibility that those of the more powerful party, probably those of the researcher's will be met, often at the other's expense. These authors contend that these conflicting needs pose many ethical problems in the research. I saw it as my responsibility to strike a balance and therefore had to find an appropriate ethical framework.

Another framework to consider as the study was constructed and implemented was one that would ensure trustworthiness. Koch argues that trustworthiness or rigour may be established in a study if the reader is able to audit the events, influences and actions of the researcher (1994:976). It is clear from various other authors that the essence of quality in qualitative research depends on the researcher as the research tool. This meant that throughout the study, it was my responsibility as researcher to develop and hone myself as instrument.
Augustine Shute (1999) a philosopher and ethicist ascribes these attributes to one who acts ethically:

- An ethicist is conscious - this implies awareness.
- An ethicist is creative - this implies recognising and naming the circumstances.
- An ethicist is critical - the implication here is that you think about it.
- An ethicist displays consistent action - implying that it is done consistently.

These attributes could describe those of a good research instrument, or a qualitative researcher. I needed to develop an honest and respectful awareness of who I was and was ‘becoming’ both as a teacher and researcher. As an introduction to this section I would like to add a description of my understanding of becoming a teacher. This was part of my attempt to recognise my own ‘sense-making’ process and offers the reader some understanding of the context in which I had to move with authenticity. It was here that I found, like Meulenberg-Buskens, that the personal and scientific are intertwined. She sees that the “…scientific moves into the personal when the researcher meets the researched in the research context” (1997: 112). In this research context I was also at times the researched.

I know that at various times in my learning to facilitate student learning I experimented and worked with different models of relating. I was never good in the ‘master-teacher’ role. Moving in and delivering the content before making a well timed retreat to a sanctuary of distance, never suited my gregarious nature. The other route, that of involvement, seemed fraught with hurdles and I had had no previous models.

In my role as course co-ordinator I was required to do both the classroom teaching and the clinical teaching, working with students in clinical settings. I was glad of this, as there was always time with the larger group and time with individual students.

After about three years in a junior lecturer’s post I realised that I had moved from offering information to conducting activities which could result in learning. I moved from preparing lectures and reading these, to telling stories at intervals during the talking. I realised that these may bring a higher level of interest and yet they remained my stories. As I learned more participative techniques and skills [first by watching facilitators of workshops and later at workshops about topics like: Group facilitation skills, Making thinking visible and Facilitating student learning], I changed various aspects of the course. I introduced journalling as a learning activity and started to dialogue with individual students about their practice using this medium. It was at this point that the affective aspects of their learning became evident. I became more aware of students own learning styles and their preferences regarding written or verbal communication as well as participating with me. Narrative and reflection became a tool I often used.
I saw students' responses to increased group work, mostly related to problem solving and began to recognise how they seemed to be much more "engaged" with the classroom activities than they had been before. I thoroughly enjoyed the interactivity of these sessions. There were also the clear voices of students who felt frustrated that they did not leave the classroom with structured notes to "learn" from. Active involvement with the topics either in discussion, planned debates, poster construction, defence or criticism of published work, was learning students found difficult to quantify. It seemed that they could not trust this learning as easily, especially when they tried to gather and file their notes for purposes of examinations. Aspects of co-operative learning and peer group learning seemed to settle some of these uncertainties.

As students expressed their feelings in their journals, they often explored these with me. There were also students with whom I developed a more frequent dialogue. I realised that as students needed to talk about some of their learning and often personal aspects of their own parenting and experiences, they invariably found someone to whom they could entrust their thoughts. An added challenge was to see whether I could broaden their base of experience sufficiently to include other people. Sometimes a student would prefer not to talk to me and initially I did not understand this. Later I realised that I did not find this easy. It became obvious to me after a while that this is certainly a trend to be expected and surely, as in everyday life, one connects with some people and not with others.

On occasion course evaluations indicated that students perceived that some students received more attention from me. I remember being very disturbed by this and as I like to resolve this kind of relational issue, I approached the concerned students to help me understand this. I was surprised to hear that their perceptions of my 'favouritism' were of students with whom I really did not perceive myself to have an easy relationship. Two were students who I had perceived as distant and with whom I had to work hard at engaging. On another occasion, it was of students who were not finding the academic work easy and who were not comfortable communicating verbally in English. I perceived that these students needed to be drawn out, and required the extra space. The last was a student with complex extra-mural commitments. To my surprise none of these were related to my perceived relationship with a student, but rather my attempts to help, draw out or facilitate students' learning. It was about the additional attention none the less. I was surprised, but grateful for a little more understanding.

The relationships with the teacher and the nature of the classroom and learning settings certainly contained established patterns. The context for the learning as well as interaction with students had been established and therefore the context of the research needed to be congruent yet rigorous. The principles of trust, respect, reciprocity and honesty would need to be maintained in my relationship with them in the role of researcher. I needed to build a bridge between my two roles for the students and myself. It had to be a bridge we could trust.
2.2 The issue of ethical comportment and trustworthiness

The question of the truth-value of a piece of work lies both in the researcher conducting of that work and in its reporting. Flinders (1992:102) suggests that there are particular ethical issues in various phases of the research process. Likewise the trustworthiness of a study can also be traced through the phases of recruitment, fieldwork and reporting.

In exploring current ethical frameworks Flinders (1992) outlines four prominent contributions in the search for an appropriate ethical framework in doing qualitative research:

- Utilitarian ethics - appraise moral ethics on the basis of positive and negative consequences.
- Deontological ethics - consider whether or not research procedures conform to accepted codes of behaviour.
- Relational ethics - suggest that research be informed primarily by respect and consideration of those the researcher seeks to understand.
- Ecological ethics - place an emphasis on the interdependent nature of relationships, striving to situate moral decisions within their broadest possible context.

The ethical principles which best suit this study and guided the interactions with students and the design of this study are the relational and ecological. These two frameworks have arisen as research has developed beyond positivist objectivism towards the recognition of ‘subjects’ and ‘respondents’ as participating contributors to the development of knowledge. The tenets of trustworthiness in research have also developed beyond the positivist scientific criteria of internal and external validity and reliability to criteria of credibility, transferability and dependability (Guba and Lincoln, 1989). Koch (1994) describes that credibility is reached by faithful descriptions from which participants and readers can recognise the experience, when confronted by it. Transferability is largely related to the “fittingness” or similarity between two contexts (Guba and Lincoln, 1989). Koch adds in order for readers to make a judgement of transferability, the context must be adequately described. Dependability of a study requires “…its process to be audited” (Koch, 1994:977). Various authors have explored and expanded on these three criteria for judging the quality of qualitative research, some of these will be included in this discussion.
Ethical concerns and issues related to trustworthiness in this research will be guided by the phases of the study. Each of these phases will be discussed including aspects of the actions and consideration of the researcher/teacher role in each phase.

- Recruitment phase
- Fieldwork phase
- Reporting phase

2.2.1. Recruitment phase

The ethical attributes described by Flinders as applicable to this phase of the work are: collaboration and cultural sensitivity. This entry from my journal illustrates how I approached the students’ (G1) introduction to the proposed research.

So I introduced the research to the class. I told them my story, from being a children’s nurse to coming to the place of teaching. I had not anticipated including the story of withdrawing from a previous M.Sc. registration, but their interest and questions lead me to share the feelings of failure. At the time my concern was primarily with the reality that temporary change in the clinical setting may be measured only because of the staff team’s loyalty to me. As I told it I realised that again there was the possibility that the students’ loyalty to me could influence this study. Of course my previous disappointment could have left them with a sense of responsibility, I will need to gauge that carefully. I explained why I had decided to do this study at this time. Introduced them to my proposal and invited criticism. They seemed surprised by this invitation. Interestingly and probably predictably, I do not think any of them read it. They seemed relieved that I had prepared an abstract for each of them.

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This entry added another dimension to the student-researcher/teacher dialogue - the dimension of concern in caring. Noddings (1986: 497) contends that "[A]n ethic of caring takes fidelity to persons as primary and directs us to analyse and evaluate all recommendations in light of our answers to questions concerning the maintenance of community, the growth of individuals, and the enhancement of the subjective aspect of our relationship". This ethic of caring is upheld in the nursing department at UCT and the curriculum is committed to students learning in this way. This incident was an early reminder and awakened a welcome awareness that the research could not happen ‘with different rules’. The issue of student loyalty and the real possibility of their disliking me as the teacher were valid. The question of students doing and writing things they wanted me to hear or thought I wanted to hear, could not be over ruled.
Like Melia (1983a) in her study with student nurses, I accepted the possibility and was grateful for the possibility of triangulation between the various data gathering methods which would contribute to data analysis. Brink (1989:59) maintains that establishing data as being "true" or "accurate" in concurrent data gathering, "...is perhaps the most crucial validation procedure in qualitative research".

The students knew me in the role of teacher from previous courses in their first year. The nature of this interaction had been respectful yet familiar and students called me by my first name. The recruitment phase was an important one as the research was introduced at the outset of their third year and they had to consider the implications of this for them and their learning in this component.

I therefore introduced an overview of the module and the semester first, then introduced the research on that afternoon. I wanted to establish the role of teacher first. Students needed to be convinced that their learning would be my first priority and I in turn had to make a firm commitment to that. This commitment has resulted in my being a participant in their learning as well as an observer and reporter. The dialogue between the teacher and the researcher has been a fervent conversation, fragments of which the reader will see. In the recruitment phase, I was eager to win the students as collaborators. I took time to explain the purpose and as much of the process as I could predict to the student group. At this time they needed to understand the benefits and costs to them and to me.

Students voiced concerns and reluctance in each recruitment over the next four years, especially about weekly journal writing. Their voiced concerns encouraged me more than their consent. After the first group interaction I wrote:

© I had the sense that I need to keep reassuring them that I would do this in co-operation and in consultation with them, because I was writing their experience and I needed them to validate it.
I did recognise some peer coercion in the first group. Some were responding to their peers' reticence by reminding them, that non-participation would not help the study or me. A clear prior grasp of the question and the methodological tradition helped me to reassure them quickly that I was looking at what was happening in the whole group. I would be compiling the data week by week, so that if there was no data from an individual, the other entries would help me to keep track of the process in that way. This adolescent characteristic of ensuring that 'all were on board in a venture' was one I often saw in the data. In the data, 'coming aboard' was not about coercion but clearly about support and making it together, a certain feature of collaboration.

As I recognised the peer interaction of adolescence in the recruiting phase, I was more able to ensure what Flinders (1992:110) describes as cultural sensitivity. I wrote the consent form in my own hand rather than introducing the formality of typing, and added a simple graphic (see appendix 3). I hoped that the coloured paper extended the invitation to read, consider and come on board. The consenting students then signed a loose insert and returned these within about a week.

It was only in the first year of the study that all the students agreed to participate. I therefore maintained participants anonymity and the focus of learning by not talking about the research in the large group setting after that initial introduction. Aspects of process consent were negotiated with individual participants after the broad context was set. This also prevented any sense of group or peer coercion about participation in group settings with me around.

An important aspect of student culture is evaluation and the acquisition of the best possible grades in course work. Pleasing the teacher could obviously also be seen as an incentive to participate. The converse is also then true and this is that those participating could expect favourable consideration of their submissions and tests. The issue of fairness was managed by visible external marking of all submitted work. It seemed that as the research focus shifted out of the classroom after that first day and students were less and less aware of it. The impact of a whole new field of nursing children seemed to quickly absorb their attention and energy.
The researcher/teacher role in the recruitment phase

I have already described this quite extensively. There was, however, an aspect of advantage to note for the students. This was my sustained presence while they were in clinical settings. I needed to spend as much time as possible with the students and therefore, instead of limiting interaction in clinical settings to certain hours, my researcher role required that I spend more time than usual with students, especially for participant observation. Students expressed that they saw this as a benefit.

2.2.2. Fieldwork phase

The qualities which should be recognised in the fieldwork phase are that the researcher does not impose on the researched and yet is also not detached from them. The specific actions relating to ethical concerns in this phase were the following:

- Reflective journals were a course requirement as in the previous course, but carried no academic credit.
- By contractual agreement an external examiner moderated all the examination scripts, not only a sample as is the norm.
- I kept a chart of clinical interaction and individual time spent with all the students in clinical settings. As students could book times and lead the interaction during clinical accompaniment with them, I had to make sure that I saw them all regularly. This prevented me from returning only to the students whom I perceived, as being good informants, in any time slots which had not been booked.

The quality of not imposing can be illustrated with an example. The second group (G2) was only approached after completion of the final examinations when marks had been ratified and published. I then asked whether I could use their journals for validation of data gathered in the previous group. Twelve said yes and two said no. I was really disappointed about one of these two, as I knew that this journal contained rich data. I had read the journal in my role as teacher and I was keen to include it. I violated the quality of not imposing by asking the student on a subsequent occasion, whether she would consider changing her mind. She refused again and I had to accept her decision.
These data seemed particularly rich in describing the dimensions of categories in the negative ranges, aspects about which I do not think students easily wrote. I had also perceived that this student did not appear to like me and although she seemed comfortable enough relating and learning in other relationships she certainly found relationship with me less easy. I later realised that recognising my imposition would have been even more difficult if the student had agreed to my second request. My imposition was a mistake which represented a coercion to participate, and I was later grateful for her refusal.

The third group (G3), a large class of 21 students, clearly related to one another out of the classroom setting in smaller sub-groups. As I sought consent, I negotiated the possibility of broader participation. I suspected that focussed and selective observation would require interviewing students either individually or in focus groups. Structuring a focus group with a small already formed social group would not impose on the group but held the possibility of conforming views and predictable discussion. I found a natural opportunity to gather an unrelated small group who consisted of students not registered to do a course in psychology in that semester. This diverse group was connected by time-tabling rather than similar or shared social experience. Scheduling did not mean imposing on their schedule and yet the advantage of being involved as their course co-ordinator, facilitated arranging this focus group session.

In that class (G3) one student asked to read my proposal and also offered criticism, she later became a rich data source. This was an articulate and clear thinking student who was facing a life crisis at the time. She was not ready to share the process of her own “sensemaking” of families, parenting and children in the class room or large group setting but found her voice in her journalling. It was at this time that I realised that some students articulate their experiences better in writing while others tell the story more easily in person. This became a guide to further data gathering and it was with this student that I scheduled the first individual interview in G3. I was already in the selective data gathering phase of the work at this time. The freedom was useful as the process of data sampling rather than sampling of participants meant that I could justify finding data in it's best form from the best informants for that purpose.
The quality of confirmability described by Leininger (1994:105) as "...obtaining direct and repeated affirmations..." of what the researcher has seen in analysis. This phase (G3) required finding these affirmations to confirm the emerging theory.

The students in G4 undertook to write journals as before and the process consent was broad enough at this stage to ask them to participate if there was any additional data required. Again only a portion of the group consented to participate, but by this time the data still required was so specific that it was easy to recognise. Narratives were included in the submission of an in-depth Ill Child assignment and students gave individual permission for these to contribute to data. This was the only incidence of data contributing to course grades in the four year period. This contribution was approximately 15% of an assignment that carried a 10% overall weighting. The focus was so evidently on describing the child that this mark allocation was considered more of a statement of value than an incentive to write in a particular way.

There was a last round of fieldwork in 1998 when G3, now in their final year, returned to a clinical setting where children were nursed. Students move directly into the midwifery module as soon as they complete their Child nursing examinations. As researcher and colleague, I had not felt comfortable to impose memories of working with children on this rapid transition into the next intensive module of the course. But one year afterwards, I mentored four, final year, students who had been participants in my study in the previous year and were now in a management module. No teacher role now clouded my role as researcher and this was an ideal setting in which to verify my findings. They had completed a midwifery and psychiatry module in the interim, both of which had turned out to be of significance in their learning to nurse children. All four of the students were also involved in their own research studies at the time. Their grasp of my work had now moved to understanding with me rather than working out what they were supposed to do to make it work.
Researcher/teacher role in the fieldwork phase

My first commitment to students remained to their learning. In effect the data often indicated more than a dialogue between students and what they were doing. There was often evidence of conversations between students' learning and the teacher. At times the student dialogue was directly between teacher and student, as the student tried to work out what needed doing in a situation. These were often about practice or relational issues. As I reflect on these situations now I return to my thoughts about walking along the beach. In these times I was sometimes knee deep in the water of the teaching experience, while at other times I was watching safely from the shore of the research, trying to avoid disturbing the water.

Recording these conversations increased my “self-awareness” a quality described as essential to the credibility of the study (Koch, 1994:977). They were recorded, sometimes in the researcher journal but I sometimes found them in my participant observation. Stepping back to look at it later in order to ask: “What was happening here?” helped me to step out of the water again to questioningly watch from my observer/theorist role as the researcher. This really was the pattern of the participant observation. I was undeniably a participant. As I worked with students as teacher, I was part of what was happening. The challenge for me in this was twofold. In my teacher role, facilitating sometimes required waiting long enough to allow a student to discover something herself. It sometimes necessitated prompting when it seemed that the discovery required only one further step; sometimes help was required to get over a small obstacle. As researcher I was with the students in the clinical setting in the role of co-worker and observer rather than in the more common, possibly more familiar, role of evaluator. This had to be held in tension with the researcher role in which I was trying not to impose by observing and yet I did not want to be detached from the activities.

As researcher I became able to “watch” my teacher behaviour and recognise student responses more clearly. This may have been more fully captured if audio or visual recordings had been possible. This was not however feasible or possible in the often varied and busy clinical settings or in the available classroom settings.
Participant observation had to be spoken into a hand held tape recorder, after the classroom session or in the 10-minute slots scheduled for this between time with individual students in clinical settings. I soon realised that I could not speak to anyone I met on leaving the setting as I could easily tell part of a story and blur the clarity of the observation by engaging with someone before capturing the whole of the observation.

Throughout this study, the challenge of not imposing and yet not being detached was a constant one. As I look back on the teacher role, which I so often pondered, I am only too aware that the same qualities that hold for the research process, hold for the teacher. The challenge not to impose on the students learning while simultaneously remaining fully involved applies to both roles.

2.2.3. Reporting phase

The qualities that should characterise this phase of the study in the ethical frameworks of relational and ecological ethics are confirmation and responsive communication. The actions will be discussed in the context of the further principles of trustworthiness.

Anonymity was important to maintain. Because students were part of a relatively small department, they were well known. As data was transcribed, names were immediately replaced with numbers. As the data was submitted for peer and supervisor review, for confirmability of the analysis, an alphabetical sequence would have been too easily identifiable in the small groups. Calling students P4 and P12 in analysis and reporting was not always easy as it brought an impersonal tone to the data. The data were however mostly student or researcher descriptions of their own experiences and understanding and therefore mostly in the first person. Where they used a peer's name I replaced this with a pseudonym in reporting. I chose not to give students these fictitious names throughout as this would have hindered my connecting with the data. Using numbers did mean that during analysis I often had to consciously recall the context of the data bit. The original list of student names and assigned numbers were documented for reference, and remain with the researcher.
There were three young men in the four student participant groups. However for the first two years there was only one. We (he and I) decided that all the pronouns would be changed to female, to avoid this young man's identity being evident. The data that seemed particularly related to his experience of being male were recorded as relating to an additional participant. This student assisted me with the sorting of data. It was a primitive way of sorting and may hold bias, but we decided that this was the best way we could do. Later data gathered from the two other young men was managed in the same way. They confirmed that they thought this to be a fair representation of data related to them.

In reporting the question of what Miles and Huberman (1994)-call *worthiness* of the project, the following must be answered:

*Was this study worth doing? What is its significance? Have I done and reported it with integrity and as best I could?*

Was it worth doing? If the initial purpose of the study had remained unchanged, a lack of constant analysis in the initial stages would certainly have rendered the results and the study less worthwhile. As described, I found it difficult to keep up with constant comparative analysis especially in the first group. At that stage the purpose of the study was to identify what helps and hinders student learning. Subsequently, guided by grounded theory as methodology, I was describing incidents as the students or I encountered them. This was to enable me to ask the question: "what is happening here?" of the data. I realised later that not analysing as the process unfolded meant that I did not recognise when I needed to start limiting the observation. The broad analysis that could happen at that stage, served only to excite rather than focus observation and data gathering. This dense description of the whole 14-week child-nursing module became the basis of a much bigger picture. The picture surprised me. It was so much more than what helps and hinders learning. The analysis of this initial broad description enabled the recognition of a larger learning process and prompted the formulation of a proposal to look at the bigger picture of these students' learning.
As it was the analysis of data from G1 being done while G2 was in the process of learning, that afforded the next best method of constant comparative analysis in the setting and the circumstances. The study was then lengthened to span another two fully involved groups of students (G3 & G4) and this allowed the methodological rigour required.

The well-reasoned use of the methods of grounded theory, in data gathering and analysis and reporting have provided the study with an integrity of design and implementation. I only realised the importance of this as the significance of the study became more evident. During the course of the study, conversations with peers and teaching colleagues in other professions helped me to see an emerging process of learning that I had not anticipated. This was, admittedly, encouraging and brought with it a clearer responsibility to report accurately. The reason for this was not that there had been any intention not to, but rather that as I had not been aiming at generalisability as a quality measure of the smaller initial study. Other practitioner’s responses to the emerging data indicated the quality of transferability. I probably only recognised the importance of rigour as I progressed. The unquestionable commitment to accuracy in qualitative research came only in the mentored process of doing it.

Miles and Huberman (1994) contend that the question of confirmability always begs recognition of the researcher’s position in the study. True to the ontological base of interpretive paradigm the researcher was very much a part of this study. Every effort has been made to acknowledge researcher bias. Guba and Lincoln (1985) talk of the neutrality of the data rather than that of the investigator. Working with a co-analyst, some peer teachers and two research supervisors has facilitated recognition of this. The question about whether the resulting theory is grounded in the data has been confirmed by students’ recognition thereof after extensive verification. The easy recognition new audiences exhibit when first presented with this work certainly indicates that the themes and the processes are familiar.
The question of *dependability* requires answering the question about auditability (Miles and Huberman, 1994). Was the process consistent and traceable for the duration of the study? This would include the process of decision making, including choice and rationale for method choice. The research design and the research process have been extensively described in this chapter. The rest of the report should bear witness to the care with which these have been implemented in the outcomes.

Leininger (1994:105) describes credibility (‘truth value’ or ‘authenticity’) as being established by the researcher through prolonged observation and participation in a setting. She says that it is “deeply felt “and confirmed by participants. Miles and Huberman (1994) maintain that the reader also has a part in gauging the authenticity of the story being told. Sandelowski (1986) says “a qualitative study is credible when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would immediately recognise the descriptions.”

Potential transferability or fittingness has been indicated by nurse educators in various settings, not only in South Africa but also in the United Kingdom. An interesting aspect of the rich picture of engaging with children is that it has also been recognised by teachers teaching children and other health professionals working with children.

In the quest for quality in qualitative research there is a relationship between the personal and the scientific discourse in which subjectivity is “... an asset to be exploited rather than a calamity to be avoided “ (Meulenberg-Buskens, 1997:112). In this chapter I have explored the subjectivity of the researcher at length recognising too that Smaling (1992) emphasises that personal involvement and reflective distance must take various forms in the different “moments“ of the research process. In the quest for quality and authenticity I have tried to describe these forms and moments, and trust that in reporting I have done justice to the experience of students learning to nurse children.
CHAPTER 4

A closer look at context

••••
"These children should be running around in the garden making mud pies and playing house-house but they can't even crawl or walk."

From a student journal during her first week

**How do student nurses learn to nurse children?** How do they think about and place what they already know in a new milieu? How do they consider and adapt to the new experiences and knowledge they discover while doing this child-nursing component in the Bachelor of Nursing programme?

Early and consistently recurring data emerged that indicated that students learn in the context of relationships with other people. **Student relationships with the children have, however, emerged as central to their learning.** Students' central concern and goal as they anticipate, then encounter and nurse children is puzzling out how they can establish relationship or connect with these little ones. My early impressions were that this might be an important context for their learning; analysis of data confirmed and clarified, however, that **puzzling out connection is the basic social process of learning to nurse children.**

Koch (1994:977) maintains that an adequate description of the context increases the transferability and therefore the validity of a qualitative research study. This study aimed to develop a theory of how student nurses learn to nurse children in this undergraduate context. The purpose of this chapter is, therefore, to describe the context in which this study occurred. The intended purpose of the study was to develop a 'substantive theory', by which Glaser and Strauss mean, "...developed from an empirical or substantive area of sociological inquiry" (1967:33). They explain that this usually happens when the concepts come from the data in the setting. On the one hand, the substantive area in which this particular research study was situated is very different from that in which other student nurses in South Africa learn to nurse children. The differences are in the nature of the nursing programme and the curriculum and the nature of the clinical placements; the students are also probably different as are the teachers. In many places the children will have similar disease conditions, but of course they, too, will be different. On the other hand, however, much of the experience of nursing children may be similar.
The introduction of the conditional matrix as an analysis tool also implies that the researcher notes the different levels of conditions in the social setting which influence the phenomenon or basic social process. By implication this means careful notice of the context in which the study occurs.

Data in this study started yielding information clearly related to the broader historical and social context from the outset. The introduction and context in chapter one familiarised the reader with the broader context of the South African health system, the history of nursing and the education of nurses in the country, as well as with the nature of the programme in which these students learn. This chapter proposes to illustrate for the reader the social context nearer to where the actual learning occurs. It has been constructed as narrative, using data as well as additional descriptive material to form a clearer picture for the reader.

This chapter will introduce the reader to the students and their experience as this emerged from the analysis of data. The particular context of these students' experience is the focus here. The three sections will describe the students, the elements of this course component as part of the four year programme and a typical clinical learning situation. This chapter provides a platform for exploring the basic social process of **puzzling out connection** of the students in the next chapter.

Sections in this chapter are therefore:
- An introduction to the students
- A description of the child nursing component - the milieu, the methods and the teacher
- A description of a typical clinical setting.

A note about format: Quotes from the data are indicated in a smaller font and indented in the text. Clarification has been added in parenthesis where required: [clarify]
Section 1: An introduction to the students

The student participants in this study were all young people between 19 and 22 years old, who had completed twelve years of schooling and were in the third year of a four year undergraduate programme. Developmental theorists would describe this period as somewhere between late adolescence and early adulthood, but this is insufficient to describe the participants. I would therefore like to introduce the students to the reader, as they are central images in the picture.

As they sit scattered around the classroom on this first day of the child nursing module, I ask them to think about being a child. A variety of activities may include drawing, choosing an object from a basket and telling about a related memory or writing a story triggered by some questions and surrounded with space and their remembering. My motivation is twofold. I thought it would help them to come into the module with some sense of knowing rather than with the assumed ignorance that comes with the blank pages and files of a new module. Knowing that they learned from and with one another, I encouraged them to share some of their memories. I want them to recognise how much is shared with peers despite hailing from different families, schools and towns.

Students came from various typically South African family backgrounds. The descriptor ‘typical’ is one subsuming both similarity and difference in the South African context. These images have therefore been compiled in an attempt to demystify and yet also to celebrate the rich complexity of a wide variety of families who provide context for the students’ learning. This description is constructed from participant’s journal entries as they introduce their families and remember being a child. The purpose is not to analyse, to generalise or to categorise; merely to introduce the students as participants. The English usage of second language students may be slightly unorthodox, but data is verbatim except where this may impede understanding.

Most students describe their family as different from others and very few think of their family as ‘typical’. They describe single and together parent families as well as numerous extended families; some families live locally and others far away. There are students who are the youngest in a family and others who grew up looking after siblings and cousins.
There are students from English-speaking families, others who speak Afrikaans (a widely spoken indigenous language derived from Dutch, Koi and Malaysian) and Xhosa (another indigenous language pronounced ‘causa’ with a loud click). In this area, like many in South Africa, many people speak two or more of these languages, often shifting unconsciously from one to another. Among the families, cultures vary from traditionally European where reading made Enid Blyton and Peter Rabbit household names - to more African oral traditions where stories and songs are the medium of interaction and learning. This generation of young people is also the first in this country to have grown up with television rather than radio as the primary mass media influence. This may partially account for the apparent uniformity in family culture.

An initial question to students was: “What do you remember about being a child?” This had both an educational and a research purpose. It assisted students to recognise and value their own experience, and for the research process, it captured the experience to inform and enrich interpretation.

As they introduce themselves, here are some extracts:

“So you want to know about my family. Well I’ll try and tell you something about the household I grew up in....”

Let us start with mothers:

“I come from a family of six. My mother is a housewife and is involved with the Catholic Women’s League.... My mother is also a housewife, although she used to be a paediatric nurse.... My mother passed away 3 years ago in a car accident.... My mother is a teacher. My Gran is the most important person in my life and I’d hate to lose her. When I think of what a difficult life she’s had, then I can’t but love, respect and care for her. I'm more closer to her than my parents.... My mother is at home with the children and the old people. At my home, far from Cape Town, they are very proud of my learning.”

Of course some memories are happier than others:

“My mom always shows concern for me e.g. do you have enough food? But that's not love.”

There are descriptions of fathers:

“My father talks a lot loudly - I often say I got both of these traits - talking a lot and loud.... My father is a human resource manager.... My father remarried two years ago.... My father is an architect.... My father always worked on a construction crew, now that he is older he sits and watches the younger men work.”
Less happy circumstances are also part of student experiences:

"My father has also remarried, but her children are totally different to what we are and we're always down each other's throats.... I haven't spoken to my father in almost a year. There is just this big barrier between us that seems impossible to remove."

Home is different, yet similar, for many of the students:

"I have a mother and father at home. My mother has not worked since my sister was born.... We live in a house overlooking the sea. My parents are trying to get us all to move out - but we keep coming back for food and T.L.C.... My mom and I, her siblings and my grandparents all lived in one house just down the way from here, I don't know how we managed but we did. My grandparents were married for 38 years!.... At the moment it is only my youngest brother who lives at home with my parents. The others are studying elsewhere. They only go home for holidays just like I do.... Our whole family lives within the area, so I have always had my aunt, uncles, cousins and grandma around me.... We are a close-knit family who believes in togetherness and upholding it with tradition. While growing up we have had and still have household rules and regulations. At the same time we have always been encouraged to become independent."

siblings add flavour to the experience of growing up:

"...I am one of seven, no one else is studying at university.... I am the eldest, followed by two brothers, the youngest is spending the year in England and Europe, working and finding direction!.... My youngest aunt is my age. We grew up like twins and we are very close. She is doing Occupational Therapy at University.... Although I am the youngest in my family, my mother was the eldest of eight."

As they recount siblings, extended family members are described:

"A few of my uncles and aunts had children when I was 10 and older. I therefore grew up babysitting, visiting and playing with a lot of them when they were babies, toddlers and older.... My mom was one of five. There is my aunt with all the credit cards. She likes shopping, especially for clothes. She is married with 2 kids and is a primary school teacher. After her comes the mad one in the family. If you hear her laugh, you can't help but laugh too. She is twenty-nine years old and is a widow with two children.... As you can see, none of my aunts are really old enough to be my mother and my relationship with them is more sisterly than aunt-niece.... I seem to acquire cousins every 2 years. They drive me crazy at times but I don't regret having them in my life. No matter how naughty they are, they won't put me off having children of my own. I do quite a bit of babysitting for friends."

And so these accounts often include students' experience of looking after children:

"I have 2 nieces and 1 nephew. They are 9, 7 and 5 years old. They are very nice children but they are wild. They drain my energy when they come over to visit. They are very restless and one has to constantly check out what they are doing because they can easily hurt themselves.... I remember I had felt a bit insecure and stupid when it came to infants.... My boyfriend has a six year old son and I baby-sit him often."
Students in this study had often had experiences with children other than those in their own families:

"I liked teaching Sunday School and also helped foster-children with their homework at a local school after-care centre.... I teach music to a little girl privately and spend most of my Friday afternoons in the hospital crèche letting the children play with little instruments. We sing together as I play on the piano and afterwards we all play outside. I love kiddies.... I have always got on well with and enjoyed children. Even in Standard 5 (about 12yrs old) I used to play with the Sub A's (grade one, usually 6 year olds)... After completing school, I did a Child Care Training course for three months, in which you learn about children up to 6 years old. For about 7 months that year, I looked after 3 boys in their home while their mother was at work. One was 4 years old and the others were twins of 2½ years. There was a maid, so I had minimal household chores.

There are students who do not like children. Some students have little experience with children, but all draw from a wealth of childhood memories. A selection of their memories of being "little", has been gathered to add some colour and flavour to this picture of the participants:

"It was so much fun to think back to my childhood and be a child again.... I remember being very happy when I was small; looking back I am conscious that my parents were always around.... My first memory is of learning to crawl up and down the steps in our flat. My parents were so proud.... I was three when my brother was born and I remember being very jealous when he arrived home. I can clearly remember making the decision to throw a temper tantrum.... I remember finding a new pair of pyjamas in the cupboard and being told by our maid that it was actually a Christmas present for me, she was always around.... My grandma would always rub on thick vaseline before we walked to school, it kept us warm.... We visited grandpa and grandma on a mission station and looked forward to receiving small gifts.... I remember camping in tents and posing for photographs under the waterfall"

Shared memories include:

- Of warmth - school clothes over the heater in winter.
- Playing house-house and shop-shop with a cousin.
- Climbing and swinging down from trees.
- Older children chasing and scaring me.
- Lying next to Ma in bed, to keep warm.
- People pulling ugly faces at me.
- Daddy tickling me

Of course memories are associated with different responses...

"It is wonderful to have such a rich childhood to look back on. I hope that one day I will be able to have children to experience all these things with them.... Some of the memories from my childhood are good, but others are locked away where they can't get out and haunt me. Many things from my past aren't resolved but I'd rather not take the risk of getting hurt by thinking and talking about them."
I trust that these vignettes have introduced the reader to the students who participated in this study. The hopes and the uncertainties that lie behind this data enabled me, as researcher, to glimpse the wealth of experience that each student brought to this process of learning to nurse children.

Section 2: Description of the Child nursing component - the milieu, the methods and the teacher

After occasional contact in first year, these students encounter children in their third year, in the course component called Child nursing. It has become evident that here they face a dual challenge. First, this is one of learning to work with children, especially with ill or injured children, during times of extreme difficulty and stress for both the child and his family. Second, there is the challenge which learning in this particular life stage of late adolescence, represents. In this developmental phase learning to work with children poses challenges that analysis of data in this study has helped me to understand better. These particular challenges will become more evident in the following two chapters. This section however serves to introduce the reader to this component of the Bachelor of Nursing programme at UCT.

The 14 week component fits into the 1st semester of third year of the programme. In the first two years the focus moves from an overview of health and the factors which impact people's health to the ill adult in hospital. The first six months encourage students to broaden their perspectives on health and family. The following 18 months are spent learning to work with adults, ill and well. By the beginning of their third year students have therefore explored health as well as had significant experiences of illness and suffering in family, community and hospital settings.

As explained in the first chapter, the focus in the third year is on children and mothers in families. The theoretical and clinical experience includes women's health and child nursing and is followed by midwifery. The research period of each of the groups (G1 to G4) was confined to the 14 week period of the child nursing component, which occurs between March and May of every year. The four participants from G3 whom I interviewed in their 4th year were the exception.
The learning includes clinical experience as well as classroom-based learning. Students spend approximately 300 hours in various clinical settings. The commitment to a health-based approach requires that students are familiar with healthy as well as ill children. In this programme the term clinical therefore does not only include time in a hospital setting, but also time spent with healthy children. The settings for this include day-care centres and a study with a family expecting a new baby as part of the women’s health and child focus of the third year.

Weeks are planned so that students’ clinical learning and theoretical input occur simultaneously, in consecutive sessions to enable some continuity. A typical week’s timetable looks like this:

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>07h00-19h00</td>
<td>Pharmacology - 45 min</td>
<td>Pathology - 45 min</td>
<td>Psychology - 45 min</td>
<td>Psychology - 45 min</td>
</tr>
<tr>
<td>Clinical work</td>
<td>Psychology - 45 min</td>
<td></td>
<td>Psychology - 45 min</td>
<td></td>
</tr>
<tr>
<td>11h00-19h00</td>
<td>Child nursing</td>
<td>Child nursing</td>
<td>10h30 - 16h00</td>
<td>Child nursing</td>
</tr>
<tr>
<td>Clinical work</td>
<td>Class-based learning</td>
<td>Class-based learning</td>
<td></td>
<td>Class-based learning</td>
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<tr>
<td></td>
<td>p.m. FREE</td>
<td>p.m. FREE</td>
<td>10h30-13h00</td>
<td>p.m. FREE</td>
</tr>
</tbody>
</table>

Child nursing consists of three distinct yet integrated subjects. The subject names are indicative of the curriculum approach:

- **Human development and behaviour**: This subject includes human biology - structure and function, growth and development and human behaviour. Aspects of the physical, intellectual, emotional, spiritual and relational nature of persons are woven into all the material covered in this subject.

- **Health dynamics** explores the factors that help or hinder the health and well being of individuals, families and communities. Socio-political, economic, geographic, cultural and technological factors contribute to the context of people’s health and illness.

- **Professional growth and practice** is the evidence-based practice of nursing. This subject is the core of students’ learning and is richly contextualised by the other two subjects. This subject always has a theoretical and clinical component.

These three subjects form the three majors of this undergraduate degree and all nursing theory is arranged within this framework. The periods, indicated as ‘child nursing’ in the preceding table, are situated together to offer more time to tackle a complex theme, to consolidate broader perspectives and to allow time for the numerous group learning activities.
2.1 Methods

Classroom activities are varied and include the use of formal lectures and participative group work. While presentation and learning activities vary, differences in the course between the four groups in this study (G1 to G4) have been related to sequencing rather than content. Recently established national priorities for child health and health service changes have been incorporated. As various opportunities relevant to student learning became available, we accommodated these in the schedule. These opportunities came in the form of public seminars, a visiting academic, individual student interest or involvement with extramural activities or sometimes a movie on the local circuit. Regular experts included parents, a parenting counsellor, a child abuse specialist, a nurse researcher, various clinical nurse practitioners and the director of the policy unit at the UCT Maternal and Child Health Unit.

Peer learning is encouraged and students may be asked to gather different information to share in co-operative learning groups. A topic is sometimes covered by students arranging a debate or presenting the perspective of a particular interest group as we design a policy document for a children’s ward. Examples of these were a hospital visiting policy or a policy for the admission of children with HIV/AIDS. Students are often asked to gather the perspectives of others and bring these to class. These have included mothers who sit with their children in hospital and those who are unable to stay. On another occasion, students interviewed adolescents to ascertain their health maintenance patterns. Students then share their findings in classroom activities.

Reflective learning occurs as students record their experiences in clinical learning journals. These journals help them track and make sense of these experiences. Students submit their journals for guidance in developing reflective learning. As I read the students’ journals, I enter into conversation with the writer. I may ask a question to understand something more clearly and I sometimes ask a student to think about the feelings they express or to explore an aspect of their experience further. This form of written dialogue with the teacher seems to suit some students well. Others prefer verbal interaction as they try to make sense of their experiences. Students often bring experiences from their clinical practice to weekly discussions called ‘current clinical issues’.
The clinical learning occurs largely in settings where children are cared for away from their families. Children may be in hospital wards, convalescent homes or in day-care settings. Here children are often ill or recovering, unable to be at home mostly due to the parents' lack of resources - financial or shelter - or access to transport to and from the nursing care setting. The acuity of clinical settings varies and the reader will notice data that has come from students in intensive care and high dependency units to wards for children who may be post-acute and recovering. There are also long-term care settings; these accommodate children who require regular dressings or immobilisation to those for children who have HIV/AIDS-related illnesses and have been left there by their families.

This learning is augmented by contact with healthy children that occurs in non-residential family placements, in pre-school and school settings. In the latter, students have a clearer 'learner' status than in institutions where they work as nurses. Here assignments require them to be participating observers and well-briefed practitioners act as 'hosts' to facilitate this observation. The purpose of these placements is not diagnosis and intervention but rather that the student becomes an accepted and accepting participant. In the family study too, this expectation facilitates students' learner role and creates a context in which they learn and experience family functioning and parenting patterns, which may differ from their own. Students have family attachments throughout the 4 years of the programme. Learning in this context is therefore not new and the biggest adjustment it seems to require is communication with a mother who seems constantly preoccupied with the demands of a young baby and an active toddler.

The family study, over a 6 month period, offers students the opportunity to see how relationships are maintained between siblings and parents. Students may glimpse the marital challenges and family coping coupled with financial implications that pregnancy brings. Here also the student relates to little ones with different temperaments while observing the growth and development of specific children. The students refer to these experiences often as they establish practice and start to clarify their own thoughts on marriage and parenting.
Student learning in schools and pre-schools is mediated by assignments developed to assist them to see and listen to children so that they can become familiar with the patterns of development in children. The observation is directed to facilitate students' understanding not only the measurable physical development, but to match this with the emotional, intellectual spiritual and relational development of children.

2.2 Description of the teacher

A description of the context of this study would not be complete without a description of the teacher. In this study, the researcher was also the teacher and the project of researching one's own practice holds numerous challenges. These are mostly encountered in the complexity of the relationship between the teacher and researcher roles and the imperative to manage these with integrity, not only for the research, but also regarding the commitment of the teacher. The researcher/teacher role has been extensively discussed in the previous chapter. The purpose of the following description is to complement the context of student learning for the reader by introducing the teacher. The description is informed by reflections from my journal (towards the end of 1998), when I found myself asking: “What do I remember about starting to teach students?” This is added as a contribution to understanding the process of student learning in this context.

I started teaching students nine years ago. Before that I worked as a professional nurse at a children's hospital for eight years. As I prepared for this task of teaching, I started trying to translate what I had learned to helping students to learn. I knew the difficulties of nursing children, but more than that I knew the joy of learning how it became easier and how much I enjoyed it. Children were my passion and often their parents were my interpreters. I knew that they needed to participate in student learning and so I often brought both parents and children into the classroom.

The students seemed to be so young; they were idealistic and excited about children. I was quickly able to relate to this energy and idealism. When I started, they were 19 or 20; I was 29. I felt as if I could relate to them, as if I had recently been where they now were. Along with that feeling I carried the responsibility of knowing and helping them to know - the practice of nursing children. I remember the responsibility as a kind of heaviness. There seemed to be so much I didn’t know, so much I should have known... so much students wanted to know...
As described in the previous chapter, I went on to explore various models of teaching and relating in the last nine years of teaching.

I also teach the second semester of first year; all the third year students therefore knew me. There was one group, G3, with whom I had to establish relationship for the first time in third year as I had been away in their first year. Rather than change the context of their learning, the data indicates that the work required to establish relationship with them may have added rather than distracted from the data. I remember one of these students asking me: “When last were you a real nurse?” This test of my credibility and trustworthiness as a role-model was so frank a question that it stirred me to re-look at my clinical competency. It was during that year that I started seeing children weekly, at a clinic in an informal settlement on the peri-urban edge of Cape Town. This proved to be valuable clinical exposure and it certainly boosted my clinical competence and brought a different kind of knowing to my teaching practice.

2.3 A description of a typical clinical setting

As indicated, part of the clinical component of the course meant that students were placed in various settings in the network of health services that cover the peninsula on which Cape Town lies. The tertiary or specialist care has always formed the core of this service and has been situated at the Red Cross Children’s Hospital. In recent years, the secondary and primary levels of child health care services have been developed and decentralised, partly as a result of government policy initiatives to bring these levels of care closer to the communities in which people live. Budgetary commitment has moved to decentralisation of care. The hospital has a rich tradition and reputation for excellence, not only in the academic community, but also among the people of the Cape peninsula and among students. They await their placement there with keen anticipation; not, however, without dread. They are welcomed at the hospital, which has a long affiliation with the University of Cape Town. In order to broaden students’ experience they are also placed at other hospitals and centres. These augment their experience at secondary care level as well as their experience of children who require long term care or rehabilitation.

Students are placed in various settings and in the limited time there are few who rotate through exactly the same units. Once again, in an attempt to bring the reader a context of these various settings, a description has been constructed to offer a glimpse of a typical clinical setting. The fictitious construction includes secondary and tertiary examples of children’s’ wards in three different hospitals.
Children's wards in all the settings look more or less the same. In construction, the linoleum floors are worn and the walls mostly painted in a nondescript colour. In certain spots there is a splash of brightness allowed by a generous donor or a renovated feature which slipped through budgetary constraints. One student described the place like this:

The hospital itself seems very old and run down and although the wards are decorated nicely they are not built in a very practical way for nursing. The whole layout of the ward seemed quite strange to me with lots of little wards leading off a main corridor. I got the sense that it would be quite easy for the children on either end of the passage to be forgotten about.

Wooden swinging doors open into the main passage of the ward. Here the first impression is noisy activity. The long passage is rarely unoccupied. The audible accompaniment cannot be described as harmonious. Children crying, loud conversations of visitors or cleaners and telephones ringing intersperse the more constant din, which may emanate from a local radio station or floor-cleaning equipment. Even when the activity subsides, it is rarely quiet and one or more crying little ones can almost always be heard.

There is usually an array of furniture lining this traffic-filled area. Cupboards have been added to contribute to the limited storage space inside the cubicles and tables of various heights line this busy lane. The tables serve the purpose of the moment. At one, a mother may be invited to sit, balancing her little one and the many bags children seem to add to the luggage of a previously simple day trip. Another serves as the waiting station for the central sterilising unit's collection and an array of head boxes. Tubing and suction equipment is balanced here in neatly knotted plastic bags. One holds a fish tank where the greenery seems to thrive, hiding the fish. On another, sits a very large stuffed bear. It carries a thread smile in an attempt to welcome children and is a reminder of a one of many philanthropic donations. A glance through the windows in the passage probably reveals the bear's smaller cousins in many shapes and sizes. These adorn the cots of children and are often more of an ornament than a comfort to a child.
When the heavy food trolley arrives, one or more of the tables are converted to dining room tables. The two sizes, large and small, do not always fit that day's occupants or the variety of mismatched chairs that are drawn closer for the meal.

Several cubicles open up out of the passage. These are divided by windows, which are mostly not curtained. The ward has a central sister's office flanked by two small cubicles; beyond these are two large cubicles, also on both sides.

My ward is very small and has 4 cubicles: 2 x 1 bed for liver patients; a 6-bed for babies and one for older children. The nurses here are good with the children. They are strict and get on with the work, yet at times they talk, laugh and play with the kids.

The rest of the space may then accommodate a high care area. Wards often have a high care area close to the swinging doors at the entrance. This area has one or two nurses assigned to remain there for the duration of a shift. The cubicles closest to the central office are used for the sickest children and may house one or more children, depending on the current need. There is often more than one cot of various sizes parked in the passage as children of different ages or needs are moved to accommodate one another and the staff. The older children and those who require a little less attention are usually in the cubicle at the far end of the passage.

Most of the child-directed activity emanates from here. The distance of the passage offers a track for running, playing catch or chasing a wayward ball. Toddlers who were cot-bound only yesterday are often seen warily testing their almost lost mobility. Anything can serve as a vehicle on this track: a lopsided tricycle, a green plastic scooter or the lower level of a service trolley. At first glance the children may all look the same. They are dressed in little open-back tunics in various shades of blue. Sometimes the ties match and can be tied to cover the child's back or tummy. In the winter, one tunic covers the front while the other covers the back. Children who are older wear bright blue cotton trousers. Like the tunics, these are adjusted to fit by rolling up the legs. Still smaller but similar tunics clothe the babies who occupy the cots. The babies often account for the majority of the ward occupancy.
In this setting, it is not common to see a mother with a child. The responsibilities of other children and a household are often more pressing than the hospitalised child. If employed, the child's mother may not easily be granted leave to remain with an ill child. This is especially true of part-time employment like domestic or other housekeeping occupations. Hourly payment invariably means no work equals no payment. Families often express relief at a child's admission to hospital as this lifts the burden of care giving. A mother who is requested to stay with her ill child may even express her displeasure, as "the nurses are there to care for children". The mothers who do remain are mostly those who are breast-feeding a child or live out of Cape Town. Of course, there are those who do stay with children, despite the discomfort of sleeping in a chair or even on the floor beside the cot. But mothers at the cot side are certainly the exception rather than the norm.

Children in the eight cubicles are usually distinguished by their age and the severity or nature of their illness. As tradition determines, children attended by certain medical specialists are grouped together. Another determinant is the severity of the illness. As children recover or require long-term care, they are moved to the periphery of the ward or they are transferred to the various secondary care settings.

One possible ward setting is drawn to illustrate this description, grouping children as they would typically occupy the 8 cubicles of varying acuity.
The 1st is the high care setting. Six children in cots or incubators are surrounded with equipment. Monitors are attached to wall railings and interspersed with bags of intravenous solutions. Distressed crying sometimes drowns the hiss of oxygen or suction equipment. Here there may be a 10 year old lying next to an open incubator. The youngest child may be 4 weeks or 4 years old.

I am amazed at how ill babies are. I can only imagine that some of their parents must feel pretty anxious about them. Some of them just lie in their cot staring disinterested at their environment, others look as if they have taken their last breath. There are however others who look as if they should be going home and this is very encouraging.

The 2nd cubicle often offers a temporary home to recovering little ones. Usually between the ages of 2 and 14 months, it is in this cubicle that one is most likely to see a toddler standing up against the cot side calling or crying. Here too, you may find the little one who has wriggled around for long enough to find a more comfortable or exhausted sleep in the bottom corner of the cot. In this space the floor is often littered with objects or toys, tossed in invitation to engage a passer-by or discarded when no longer useful to distract or occupy a calling toddler.

The children in my cubicle were all under one year. Most had pneumonia or pneumonia and TB. There was just one child that nearly had me in tears. Four months old and she has TB, pneumonia, reflux, has cerebral palsy (blind and deaf). It is just difficult to accept that one child can have so many health problems. I don't understand. I felt kind of helpless.

The 3rd, 4th, 5th and 6th cubicles are similar in that these smaller areas offer space to children who require some containment. They may require terminal care or be chronically ill. Well known to the staff, these children literally 'move in'. They sometimes come with their own comforters - mothers, duvets and teddies. In these spaces one may also find children on the long 'investigations' trail, ill and awaiting diagnosis. Here one often sees mothers, new to the hospital environment and worn with anxiety and anticipation of the worst.

The sister asked me to care for a little girl in one of the side cubicles whom she felt needed special attention. I entered the room and first instinct was to just stand and watch. What I saw was someone desperately ill, struggling to survive and completely reliant on the machinery to which she was attached.
In the 7th cubicle one finds the profusion of infections which plague small children, especially those from less affluent homes and communities where it can seem that nothing but despair and struggle are resilient or strong. Recurrent bouts of diarrhoea are often precursors of other infections. The nappy bin in this area is the one most likely to tilt its stainless steel lid open with its load of pale yellow or green disposable nappies.

Most of the children are very ill with infectious conditions such as meningitis, pertussis and diarrhoeal diseases and the majority are HIV-positive. After the feeds and nappies, the observations had to be done, then there are more nappies. So many have raw bottoms, probably because there are not enough nappies and they already have compromised skin integrity.

The 8th and last cubicle is often home to recuperating children whose own homes cannot accommodate them. From here children negotiate their needs in various ways. Some curry favour by helping, others by shouting and running; mostly they become resigned to obey a new set of rules, with the changing people and their very different ways of relating.

These children were almost all here because of social implications and neglect. It is almost an irony that they are here because of neglect and developmental stunting, but every one is so busy that they don't even get any stimulation. Parents who have their children here also face challenges. Most of them live far away and can't even afford transport or are feeling so guilty that they don't really want to come and visit - what a vicious circle!

Apart from the bustle of children, there are registered nurses (called sisters), staff and auxiliary nurses, all dressed in white or navy blue trousers with white tunic tops. They carry their distinguishing devices on their shoulders. Occupational and other therapists are distinguishable by insiders, while medical personnel are characterised by their visible stethoscopes rather than white coats. There are often glimpses of women in salmon pink or green who assist with housekeeping. In a children's ward they are not always limited to cleaning and are sometimes seen holding or chatting to a baby, often having a conversation with a mother.
The presence of mothers in this context is an interesting phenomenon. As one student observed:

There are no visiting hours. That only means that there is no influx and exodus of people at certain times. The mothers, who are here, are here all the time and those that are not, rarely or never come.

Mothers who have brought children from far away and those who breast-feed stay in the ‘mother’s room’. This is very basic accommodation, offering a bed in a dormitory setting with ablutions and meals. Even though present and caring for her child, these women are not usually involved with decisions of care. Many of the mothers come from inland, some via an hour or two’s travel by bus and others from as far away as a full day’s travel. Mothers often speak Xhosa and do not confidently manage either of the other two languages familiar to most of the staff. It is not uncommon to see a mother standing at the window looking out and far away longingly.

Extended families are a characteristic of many local people and the restriction of two visitors per bed can be a difficult one to enforce. Family visiting is more frequent at weekends. At these times families of up to ten or twelve may visit a sick child. The scenes at the hospital are now festive as groups of beautifully dressed people arrive. They carry food: plates covered in cloth or plastic, crisps or bags of assorted fruit. Siblings, cousins and friends come too. They come dressed in their Sunday best: little girls with braids and colourful hair ornaments, little boys in shiny leather shoes or various versions of big brand track shoes are accompanied by adults claiming kinship with a variety of head coverings.

So they come, visiting this unfamiliar yet familiar place. As the children and their families have come, so the students come too, to meet them in this unfamiliar territory. This chapter has introduced the reader to the students, the curriculum and the clinical settings in this study. The following chapter describes how students puzzle out connection as they learn to nurse these children.
CHAPTER 5

The model: *Puzzling out connection*
"...they think of children as playing and they anticipate playing with them..."

When starting to nurse children, the students anticipate that children play and that this is their most important pastime. Students’ expectation of childhood is that it should be a happy time, whether their own experience confirms this or not. This quality of connecting happily with the children they nurse and puzzling out how to do so, is the core of the emergent theory, which offers an understanding of how student nurses learn to nurse children.

This chapter presents the reader with the findings of this study. The basic social process in which students engage when learning to nurse children is puzzling out connection. The evidence for this will be presented here, and the grounded theory that has emerged from the analysis will be fully described.

**Puzzling out connection** is the phenomenon that has emerged as central in this enquiry about how student nurses learn to nurse children. Early data and analysis revealed that students related all their learning to encounters with specific children. In the field they asked questions about specific children and their concerns were peppered with how to do certain things for children, but specifically how best to perform these actions for a particular child. As the teacher, I soon realised that ‘best possible’ meant so that the child would still like them or would not cry – clearly relational aspects of ‘doing to’. They spoke often of trust and their dilemma around hurting children. I soon saw that there were specific ways in which they worked out how to be with and relate to children. These were influenced not only by their knowledge but also the cues they received from those around them: the adults and the children. In the course of constant data gathering and analysis this process of working out the “how” of their interactions became more apparent. In theoretically describing what was happening, I realised that they were puzzling out their interactions with children.

*puzzle (v):* find out by patience and ingenuity; perplex

*puzzle (n):* bewilderment, perplexity; perplexing question, enigma. A problem designed to test one’s knowledge, one’s ingenuity or patience...requiring hard thought. [Oxford dictionary, 1964:841]
As they searched to find the rules or instructions for this puzzle, I saw students strain at their knowledge and draw on the far reaches of their ingenuity. I also saw their patience tested. They struggled with the fact that playing is not what all children do, and most of all grappled with the fact that working with children was not a fun filled game. Students tried to find certainty about children and how to approach them, often because of the complex and difficult nature of the tasks. Puzzling it out certainly made hard thought necessary!

'Puzzling' was clearly the best descriptor, but what were they puzzling out? In pursuit of knowledge, they were trying to match the pathology to the signs they saw, they were keen to understand how children responded at different ages and what paediatric nurses did differently from 'adult' nurses when monitoring and caring for children. But the overriding motivation was their need to make contact with or 'connect with the children. The knowledge was peripheral: it seemed merely a means to the goal of relating to the child in order to elicit a response. The phenomenon of puzzling out a connection emerged as being central in this setting, where students learn in the context of actual relationships with children. Learning activities are geared to the students' experience and current needs. This discussion of the findings is therefore offered in the context of active learning in real settings, rather than based only in theory or in the classroom.

As there were both male and female students and both boys and girls are described in the study, the female gender will be used for the students and the male gender for describing a child in general discussion. In instances where the interaction occurred differently, the names of children will indicate this. Although the names of all the students are known to the researcher, none of these will be used in descriptions. Students are recognised by a number, which remains constant throughout: e.g. P4.1 indicates the first participating student in G4. In this text, the names of children have been consistently changed to facilitate reading and to prevent de-personalisation of the data while maintaining anonymity.

Quotes from the data are indicated in a smaller font and indented in the text. Clarification has been added in parenthesis [ ] where required.

Icons indicate the source of the data.

- Focus groups
- Student journal
- Narrative descriptions
- Participant observation
- Researcher journal
- Interviews
Puzzling out connection: the model

- Playful connecting
- Dutiful safeguarding
- In relay with mother
- Distant doing

Fig. 5.1
Section 1: The process of puzzling out connection

What students do as they puzzle out a connection happens in clear phases in the process of learning to care for children: Refer to figure 5.1

| anticipation | encounter | connection | engaging the child and/or getting done |

These phases of the process may have been expected as relational phases, but their emergence as part of the learning process is indicative of the interwoven nature of interpersonal relating and learning to care in nursing.

**Anticipation** is the phase prior to meeting a child or children. For the student, anticipation could be positive, as she looks forward to the encounter or negative, as she dreads meeting children. Anticipation is followed by **encounter** with a child or children. Both of these initial phases set the tone for the student as she puzzles how to care for the child. There are four patterns of making the contact or **connection**, which have the consequence of **getting done** and **engaging the child** or just **getting done**. These are: playful connecting, dutiful safeguarding, in relay with the child's mother and distant doing.

Analysis has revealed that these distinguishable patterns, or ways of connecting, do not necessarily follow a sequence that can be described as a process. Each encounter with a child seems to bring a different set of variables to bear on how the student will engage the particular child. These patterns are therefore the result of the various conditions, which influence the student as she puzzles out how to connect with each different child or group of children. Each student and child brings a context to the encounter. The conditions that influence the phenomenon of puzzling out connection are, what the student remembers of her own life experience, childhood and professional, and the presence of others in the setting. These others include the student’s peers, teacher, staff in a care setting and also her family. The conditions that cause the student to puzzle out connection with a child are twofold, namely responsibility and knowing.
Students’ perceptions of their responsibility and what they know are central to their trying to work out what to do with the child. In essence, they try to work out how best to connect with the child so that they can handle a task or instruction.

As students puzzle out a connection, it is like a ball being tossed between players in a game. The ball could be likened to the responsibility students’ experience. Either the student will toss it away quickly, almost unwilling to hold onto it for too long; it is as if holding the ball incurs some penalty in this game’s rules. So they play with the child, they buddy and compete with the child. I have called this playful connecting.

At other times, the student thinks that being the nurse means that responsibility for the child, mostly for his safety, is totally hers to handle. In this situation the student makes sure she catches every ball which comes in her direction. She guards it carefully, she worries about doing it properly and may get angry about being assisted or at other times at not being relieved of her juggling burden. I have termed these actions dutiful safeguarding.

In addition there is also the situation in which the student catches the ball and holds it for just long enough to check who is ready or able to catch it at the next pass. She seems clear that the goal is that the child’s mother (or parents) take over again. She sees them as able and willing to resume their responsibility for the child in the kin-relationship of parenting. I have described this as the student acting in relay with the mother.

A fourth option is avoiding interaction or participation in the game. The student may think that she does not know the “rules” or does not have the skill to participate; mostly, however, she seems to make contact but seems to be avoiding engaging the child. She will complete the tasks that she has been set, but does these with distance from the child.

At one point, analysis seemed to indicate that students learn to relate by using a sequence of these actions. The first is a novice response leading to learning or experimentation with skills until reaching a situation of “being in relay” with each child’s mother, while “doing at a distance” seemed the least appropriate choice of action.
The complexity of constant caring for many children in a ward or other setting, however, reveals that while skill in these actions may be successively acquired and then refined by the student, once learned they are not necessarily always used, but are rather applied, to different children in different situations.

Students soon realise that nursing children, which they thought would mean playing with children, becomes a very real and much heavier load than they anticipated. As they puzzle out a connection with individual children, the gravity of the circumstances and the unfamiliar setting of children’s wards often leaves them seeking new ‘game rules’. Each interaction may be completed according to the ‘rules’ the student worked out, or it may not go as she anticipated. The consequence of this puzzling out by the student, is that the job gets done and she sometimes engages with a child. For the student however, the central process is having puzzled it out. As the research question directed observation towards what students did in order to better understand how they learned, this theory is offered as a contribution to understanding the complexity of learning to nurse children.

The following data piece is from participant observation of one student group, the first time they encountered children in the course component. The setting was a preschool and the purpose was an opportunity for students to meet and observe children who were not ill. Already the students displayed clear strategies of interaction. I did not recognise the student’s interaction strategies at this early stage. It was as I was gathering and writing the final analysis that I recognised the strategies of interaction that students use and modify as they progress.

© I entered a rather sunny large room filled with four year olds and much activity. To my left one of the students was having a very involved and complicated conversation with three little girls. She had a nurse puppet in her hand and they were negotiating, it seemed as to whether the puppet should be on or off her hand, or the story should be told or not. The student was bent over...had all three of the children at eye-level and a big smile on her face, chattering and serious when the conversation seemed to require that.

To my right another student was helping some little ones to find what they wanted. She was not really interacting with them. It seemed as if her task was to facilitate their getting their lunch boxes. She was helping them to move in the direction in which they needed to go, but they all seemed to be heading in different directions.
Another student stood uncomfortably in the far corner. She was playing with the child, not verbally interacting: just throwing a beanbag back and forth. She seemed to be almost practising, repeatedly throwing, and throwing and throwing. I could see no interaction between them, verbal or otherwise.

I moved to the large outdoor area, which was occupied by large wooden structures on which the children climbed and clambered. Here I found one of the students standing next to the slide looking quite anxious. She was trying to orchestrate the play of four five-year-old boys. She was trying to get them to take turns in coming down the slide. Their intentions were different. Some of them were climbing up the front, or clambering up the sides, impeding whomever was at the top from sliding down. The student looked exasperated and desperate that they were not listening to her. Another student was running around the playground...she seemed tall and leggy among the little ones. They had somehow caught on to following and there was a train of about six little ones running rapidly round the playground led by this lanky laughing student.

Two more students stood pushing children on rubber tyre swings. Back and forth, back and forth. Now and then they chatted to each other. They seemed to be on the side, watching.

In this pre-school setting, the interaction strategies are as yet unaffected by the added challenge of illness and injury. But the underlying social process of puzzling out connection was evident in the students' writing and discussion. The context which the ailing or suffering child brings to students' puzzling, increases the complexity and will be the focus of the findings described in this chapter.

How the nature of puzzling out connection as the central process of learning is described

As the students anticipate and then encounter children, there are a number of conditions which influence their puzzling out. These tightly interwoven conditions are described as contextual, intervening and causal conditions to bring clarity to the emerging process. The nature of these three types of conditions will be defined and extensively described. This will be followed by a full description of each of the strategies the students utilise as they puzzle and learn. The section is concluded by a presentation of the consequences of undertaking connection.
Strauss and Corbin's paradigm model has facilitated the emergence of puzzling out connection as the central phenomena or the basic social process of learning to nurse children (Strauss and Corbin, 1990: 99). This paradigm model was used to guide the analysis and to establish the relationships between the core categories from the data, it is therefore a useful guide to the reader through the process of learning. Refer to Figure 5.2

After a brief description of the term “conditions” used in the study, the sections follow in this sequence and are entitled:

- Contextual Conditions,
- Influencing Conditions
- Causal conditions.
- Actions
- Consequences of these actions to students’ learning

Figure 5.3. is a more detailed representation of the model. It includes the conditions with their properties and dimensions. The actions students choose are named but fully described in figures 5.4; 5.5; 5.6 and 5.7.
Puzzling out connection:
the application of the paradigm mode
Conditions

Although the process of puzzling out connection is described in a linear fashion in the text, in reality it is a complex transactional system in which related conditions interact in a recognisable way. The conditions which have emerged in this study are described as contextual, causal and intervening conditions.

Contextual conditions are those which influence the very context in which the interactions occur. The Causal conditions are those conditions which cause the student’s actions or interactions. The Intervening conditions are those which help or hinder the social process. It is apparent that these three sets of conditions sometimes facilitate and sometimes hinder students’ puzzling out connection with children. The data analysis indicates that consequences of students’ actions or interaction strategies in turn contribute to or become the conditions affecting the students’ puzzling out and connecting in subsequent interactions with a child or children. This concurs with Strauss and Corbin’s conclusions as interrelated levels of conditions are recognised. These will become clear to the reader as the actions and consequences of student interactions are fully described.
Puzzling out connection as the basic social process of learning to nurse children

- Playful connecting
- Dutiful safeguarding
- In relay with mother
- Distant doing

Fig. 5.3
Section 2: Contextual conditions

These are the contextual conditions surrounding the interactions of the individual, the group and collective and are at the core of the conditional matrix described by Strauss and Corbin. The contextual conditions affect the actual context of the phenomenon. The actions pertaining to the phenomenon (puzzling out connection) are influenced in significant ways by these conditions. As we consider the transactional system of learning to nurse children, the level of conditions that seem to be closest to the phenomenon puzzling out connection, is the context of the individuals, namely, the child and the student.

In considering the context of learning in this setting, it may be argued that the contextual conditions are much broader. Such conditions as those of a third world country in transition, a high population of children or the absence of constant mothering of ill children, might seem to represent a more significant context of this phenomenon. Again, the educational disciplines of learning might argue that the learning situation or the methods of teaching are at the contextual epicentre of learning. The psychological perspective might contend that the personalities of the student and their temperament or intelligence quotients are central. In this study, however, these factors have been found to contribute less predictably to the contextual conditions than the factors related to the nature of the student and the specific child with whom the interaction occurs.

After the initial analysis it did seem prudent to consider student learning styles and temperaments. These specific measurements had not been part of the study design and would therefore be difficult to capture for the whole study group. (G1 & G2 had already completed the module and moved on; some had already graduated.) Individual students had not been sampled and were not being followed.
The question that directed theoretical sampling remained: "What happens as student nurses learn?" The action orientated direction of the methodology and the fact that the conceptual basis was that of social process rather than psychological process aided the decision at that time to retain the central direction of the work. The data yielded "what students do as they learn". The core methods of data gathering were observation and dialogue rather than psychometric testing and this was maintained.

Data gathering was directed by focussed questioning. Theoretical sampling allowed the emergence of the central themes defining the context of the phenomenon as being the nature of the relationship between student nurses and children. This realisation allowed the researcher to recognise a key question that had emerged from initial analysis: "What draws a student to a child?" This in turn led to identifying the characteristics of the student and the child that have clearly emerged. These can be described as relational attributes, rather than psychological or educational attributes. The contextual conditions that emerged were therefore called 'characteristics of the student' and 'characteristics of child'.

The characteristics of students were not predictable in terms of their temperament or personality traits. They were not consistent with anticipated or previous academic scores. Student characteristics that emerged as contextual conditions were twofold: They were firstly related to whether the student likes children and secondly, to the student's perceived resources at the time of interaction with a particular child. Resources and how these are related to the student's relational capacity in a specific situation will become clear in the following description. The qualities that have emerged as contextual in the child, are related to the conditions which attract the student to the child. These also include those factors which distract the student or cause her to avoid the child.

After much consideration and returning to the data on many occasions, the characteristics of the student and the child as central players in the learning are offered as the context for the phenomenon of "puzzling out connection" as student nurses learn to nurse children. These conditions meet the criteria set by Strauss and Corbin in an unexpected manner: A context is a particular set of conditions within which the action
interaction strategies are taken to manage, handle, carry out, and respond to a specific phenomenon (Strauss and Corbin, 1990:101).

The conditions or **characteristics remain constant in each interaction** in that the student enters with and maintains her resources and stance about children. The child’s verbal ability, prognosis and mother remain constant in the situation. These characteristics are not usually changed by the other conditions, either causal or intervening. They are therefore contextual for "puzzling out connection." As indicated before, the consequences of one interaction may affect the next. In the next interaction, the new context is again established and then remains constant for that interaction. This means that learning and experience may strengthen resources or cause a student to like children more or approach a very ill child more readily, thus changing the context of her subsequent encounters with children.

The contextual conditions presented here are therefore those surrounding the student and the child she encounters. In this section the characteristics of the student will be presented first. These will then be followed by the characteristics of the child.

Contextual conditions are evident in the first two phases of the process. During the anticipation phase, the student’s characteristics are described. These often affect the encounter. Once the student encountered a child, the characteristics of the child become evident and are described.

**Anticipation**

- Characteristics of the student:
  - likes children or not
  - has resources or not

**Encounter**

- Characteristics of the child:
  - mother present or not
  - child attracts or not
  - child is verbal or not
  - obviously poor prognosis
2.1 The characteristics of the student

The students in this study have been described as adolescent. A full discussion of this and the implications of the findings in this study on their learning at this life stage will follow in the last chapter. The characteristics of students have emerged as contextual to the phenomenon of puzzling out connection as students learn to nurse children.

The emergent contextual properties in the student’s relationship with a child are the following:

- The student likes children or does not.
- The student has resources or does not.

The question of liking

The first quality, is that the student either likes children or does not like children. This is one of the first characteristics evident in students as they start this component of the programme. ‘Like’ is used here as an emotional quality of taking pleasure in, or enjoying, that sets the initial context for students puzzling out their relationship with children.

Students easily verbalise their liking children and it is often the reason they give for looking forward to working with children. From the outset data indicated that students use working with adults as a basis for comparison. Students often anticipate liking children because they are different from adults. This seems to be enough to kindle a liking for children even if students have little experience with children. Previous experience with children (baby-sitting or voluntary work) may influence liking children, but this is not consistent enough to be a predictor of liking children. It is clear, however, that students’ liking of children is not related to whether they like people in general. The following excerpt illustrates the use of adult nursing as a comparison:

I love children, but I didn't know what it was going to be like to care for a child in a hospital. But there's no way I possibly will be going back to adult nursing because child nursing just offers so much more in terms of getting to know about a person, because adults have the ability to tell you how they feel, and withhold information...with children, they never lie. They are so honest, they just tell you what they think, they let you know...
There are cases in the data where a student offered the information early in the course that they did not like children. These students sometimes announced their change of mind towards the end of the course.

Congratulations, Minette. You have managed to win me over to the enjoyment of child nursing. In the beginning I said I hoped I would become patient - well, now I know I was patient all along. I learned how to have fun with children. I learned to accept what they give me and to accept what they take. Actually, I think I prefer nursing children to nursing adults, although I preferred the sick children to the well children. I even kept a journal. I feel I can perform clinical skills with confidence and competence with an understanding and empathy for patients and family.

This student who initially told me that she did not like children was now expressing "an enjoyment of child nursing". The contextual conditions changed for this student during progressive interactions and subsequently her puzzling out connection changed as she engaged children. This is an example of how the consequences of interactions can affect and change contextual conditions in subsequent interactions.

Not liking children emerges from the data less obviously than the characteristic of liking children. It is clear that students find the fact that they do not like children difficult to own and to articulate. The data display an unspoken expectation by student nurses that they should like children. This reticence may also be related to wanting to please the teacher initially, especially a teacher who is expressly committed to nursing children. The fact that a student does not like children often only emerges when a peer points out that a student does not like children or when a student compares her feelings with those of peers. This data excerpt occurs just after one student's lengthy description in a focus group of how much she likes children and this makes learning easier.

Researcher: Can I just ask, is your experience similar? (to the other students) Did you always love children?
Student: No!
Researcher: How does one then learn to nurse them, if you didn't always like them?
Student: Well, I think your motivations on a lot of things you do is different. I mean I pick them up more to stop them crying than because I want to cuddle them. I mean I'm doing the same thing but my motivation behind it is vastly different.
This student indicates her observation that others' liking children is their motivation for action. She clarifies that her motivation is less about herself than it is about the child and his need. It is interesting that she did not change her mind about liking children in the course of the data collection period. Various data indicate her observing rather than engaging a child. She describes how she tries to work out why a child is behaving in a certain way and how she ponders her actions with the child. The context for each interaction, however, remains her clear statement that she does not like children.

I think I just got to be a bit more confident with children. I found that children were not quite as breakable as maybe I thought they were at the beginning... I don't think I'd ever work with children, but it was better than I thought it would be before I started.

There is an unspoken expectation among the students that young women should like children, while this does not necessarily hold true for young men. This expectation, which may influence the context of young men who choose nursing, can be traced outwards from the core of the conditional matrix in this phenomenon of puzzling out connection with children.
During the four year period of data collection, students encountered only one male nurse working with children. At the sub- and the organisational levels the roles of men in the nursing profession were therefore not clear. At the UCT Nursing department there were often 3 or 4 young men who enrolled in first year, but in each year this number had diminished to one by the third and final years. The majority of male students in the medical faculty were studying medicine and the male nursing students were often called “doctor” in the wards. Children and parents were not consistently corrected, except by the students themselves who often displayed embarrassment at the incorrect title.

The community level of the conditional matrix may offer some understanding of this behaviour. The children whom students encounter often hailed from poorer families. These are families who tend to hold an unquestioned respect for the authority of the medical profession and of nurses. Traditional career expectations of young men pervade most South African communities and nursing as a profession is not a usual expectation. Careers in caring and education are traditionally ascribed to women. Although men have entered these professions in the nineties, nursing has remained a career that few young men choose. Career choice is also indicative of the roles ascribed to men and women in communities in this country.

At a national level, the country is characterised by a newly established democracy and an increasingly youthful population with promises of career success in the wake of disrupted communities and families. Political upheaval and migrant labour as well as matriarchal and single parent families certainly contribute to the conditions young men bring to their role as student nurses.
This characteristic of students, particularly as it pertains to the young men in the study and their acknowledgement of whether they like children or not, has been traced using the conditional matrix. This illustrates the complexity added to the context of relating to and nursing children. Their gender cannot, therefore, be ignored in the discussion.

The three young men who contributed to data in this study (one each in three of the four student groups) did not display similar characteristics regarding liking children. One was outspoken about his enjoyment of children, another said that he really had not thought about it and the last said he “didn’t mind children”. The responses of these students were borne out in their relationships with children and their mothers. Like their female peers, their feeling for children in general created the context for their puzzling out connection with the children they encountered.

An interesting feature of the young men in this study was the nature of their interaction with children. Their context of learning seemed to be from within their perceived role as men. They appeared to handle children less frequently than the female students, and their interactions were often goal directed and performed with a greater physical distance between themselves and the children. This did not, however, mean that they were emotionally distant from children. Their physical contact was merely different from that of the young women, and they were observed playing boisterous games with children who were less ill. Again, interactions with mothers of children seem to be more instructive than listening. This could also have been related to their age and uncertainty in their role and was also, on occasion observed in female students. Later data from fourth year students indicated that more experience with people, especially mothers and families in the context of midwifery and psychiatry, afforded them more empathy with mothers as their understanding of situations increased.

These impressions of young men and their interactions with children arose from overall observation. Deductions that might follow cannot, however, be sufficiently grounded in collected data to be presented as part of these findings. It appears that ‘being male’ might add to the context of kind of student, but data from this study is insufficient to ground this.
The contextual condition related to whether the young men liked children was, however, similar to that of their female peers and set a context for the learning.

**The question of resources**

The second characteristic students bring to the context of learning is whether they have resources or not. Here the word 'resources' is used to include that which students perceive as under-girding them, their means of support and defence or their possibilities for aid. The source of assistance or strength is different for all students.

And to me if the child cries it needs love and attention. It needs all the undivided love and attention. But you are surrounded by so many, how do you divide yourself and give everything of yourself? And that's what I find particularly challenging, working in the wards for example, because there are just so many of them. And when you are busy with the one, the other one will be tagging and hanging at you also. How do you do that? And that is what I find particularly challenging. I didn't know how to deal with that. I still don't know how to deal with it.

It is this expression of having to give so much to the children in their care that initially alerted the researcher to the students' awareness of their resources. It was the descriptions of a lack of resources, rather than an abundance that initially emerged from the analysis. Recognition of their lack, led to evidence of their perceived resources emerging from the data. Student journals often described feelings of fatigue and being drained:

- I was feeling unwell and emotionally and physically it was hard for me to cope with the demands of crying babies with dirty nappies, hungry tummies and lonely hearts.
- I worked in high care and by the end of the day felt physically and emotionally drained. Another thing, children are definitely more emotionally tiring than adults, probably because they demand more attention.

Few student journals do not contain these expressions of fatigue and exhaustion. Another resource-related theme is that of student illness. Students subscribe to the popular belief that children harbour more pathogens than adults and that as they come into contact with these "unfamiliar" microbes they become ill. The three months of nursing children are characterised by minor illnesses, as students seem to be off work often with flu or diarrhoeal disease. Generally, the children receive the blame for this. In the second week with one of the student groups, I noted the following:
There were two students off with severe Gastro. Later one said to me: 'those horrible little children gave it to me.' Week 2, min journ.doc 24-25

One student considers her illness in her journal:

I have thought what could have caused me to become ill. Is it from one of the children at work or is it just doing the round? I hope it’s not from working with the children because I am careful, e.g. aprons, washing hands. Anyway, I just hope I don't get sick again soon.

P1.10 W2codat.doc

In this deliberation regarding the cause of the illness, the student’s focus on external causes is interesting. Even though students describe their stress and fatigue they seldom connect these with their own resistance. There are also students who will confess that they sometimes call the wards and report illness when they are not physically ill. Students only work these long shifts (07h00 to 19h00) because this is the norm in the services. Similar shifts facilitate team acceptance but there is provision for “time-out” days in the Nursing Department’s policy and therefore also from the work setting. However it remains difficult for students to acknowledge their need for respite other than for physical symptoms.

I was still feeling exhausted from yesterdays 7-7(a shift lasting from 07h00 to 19h00) so it was a real effort for me to get to work today.

Feeling tired and unwell, irritated because I would rather have day-off and enjoy it.

P1.4 journal.doc 124-125

The following student emphatically describes the difficulty of having her resources taxed by not feeling well.

Feeling awful today! Not really good with screaming babies at all because I just wanted to join in and cry! (the whole day). Children are so emotionally, mentally physically and spiritually draining - they take EVERYTHING! Nursing children involves a lot of giving and very little receiving! although it is rewarding to pick up a little screaming so-and-so and with a little T.L.C.(tender loving care) and 5 minutes to have them fast asleep.

P3.3 Journal.doc 35-38

Resources referred to by students vary. The range of resources they describe is captured using the terms internal and external resources.
**Internal resources** are those which students describe as deriving from their experience, their knowledge and their emotional response. Evidence from the data suggests that the students' resources pertain to various aspects of their beliefs and values which have been shaped by their life experience. It is often in these beliefs and values that the decisions about action are seated. Students' beliefs about children and how they should be treated, as well as what they consider to be important, are related to the resources they have. Their concerns about resources and the rules they make as a result of what they believe, often direct their involvement.

And I've learned that ever since high school. You know everywhere you go people ask you, will you be able to come back next week? Next week and the week after that? If you can't commit yourself then don't do it because people look forward to it... It's like I'm going to be in the wards on Monday and Tuesday, but then I'm not going to be there. And you might never see them again. P4.1 Focus2.doc 272-277

Students' emotional burdens often drain their resources. These burdens are not always necessarily related to nursing children:

I realised that all the fears and anxiety I was carrying around had been burdearing me so much, unable to see past the emotions welling up inside me. I often use my work as a form of escapism because I can give so much to the children and I can receive affirmation and self-confidence through them but... I can no longer put on a brave face and give the appearance of a strong, confident, coping person... P3.5 Journal.doc 335-348

It is evident that, as students start to work with children, they consider their own life experience. As they explore their beliefs and expectations about children and having their own children, painful memories may further tax their resources:

There are many things in life I have had to 'face' and it's going to be difficult for me to write down emotions of feelings [about children while] not involving personal issues. P1.9.journal.doc 11-15

**External resources** include supportive people and familiarity with the setting. A student describes her resources thus:

I know how important a family is [because]. I lost mine three years ago and now can only build on the little one I have got - my sister and I. This is enough for now, not everything I would wish for but the support, encouragement and love I need. P1.9. journal.doc 103-108
Her resource base is in the family she has built with her sister. Another student dealing with a recent family trauma recognises her external resources in her friends whom she initially thought had little to offer:

I realised that if I am to get through this trauma as a whole person I can't do it alone - I have to allow other people to show the caring and support which I have rejected and denied.

There is evidence in the data to suggest that the students' sense of their own resources are more important in setting the context than their experience is. This is borne out by the fact that students may have had similar experiences, and yet one may utilise the experience as a resource while the other does not seem to refer to the experience at all. It seems that for one an experience was a positive learning experience, while for the other it was not. The latter could merely represent a missed learning opportunity or actually be an impediment to the new situation.

A good example of this is students whose mothers teach in pre-schools.

The first is an observation of a student on the first day while watching her peer group interact with children ...

When I went up to her she said her mother has a playgroup and so she is quite used to children. Especially of the age-group 4 to 6, and she was watching how the others [classmates/students] struggled to keep children within limits. She said she was noticing how the children tired them. How students allowed them to climb on top of them and play with their hair. And she felt that one learned how to not allow that, or to set boundaries more clearly by example (her mother's).

The second comment was made by a student who only mentioned the fact that her mother was a pre-school teacher after completing the whole course component.

Researcher: Would it have helped to work with children who are well first? I'm just wondering...having children around before you began?

Student: Not necessarily. I mean with my mum also having a pre-school, I have sometimes been around children who are yelling and screaming and running around and driving me mad!

It is clear from this data that common experience does not result in similar resources. The conclusion is that the students' perceptions of their resources are more significant to their context than their experiences. This principle can also be applied to learning.
The nature of the student’s resources at the time of the experience rather than her experience is the context of the learning. It follows that if a student does not have the resources, or feels unsupported or without defence, she is less able to engage the situation and therefore less able to learn from the experience. The students’ resource therefore sets an important platform or context for the whole process of puzzling out connection. This important finding is further explored in the discussion in the following chapter.

2.2 The characteristics of the child:

In the anticipation stage the student sets the context for the initial phase of working with children. In this phase, that of encounter, the child enters the field and enriches the “game” with additional context.

Analysis of the data indicates that there are certain characteristics of the student, which bring context to her interaction with children. She brings a personal quality of being ready with affection or uncertain about the encounter. She also brings resources and sometimes childhood burdens, which are often unexplored. Holding these, the student encounters each child, and with each different child moulds a particular interaction. Each child brings colour and variety to the context of their interaction. The impressions formed from the first glimpse of the child to their good bye are the context of their relating and the student and the child themselves remain the context of puzzling out connection.

The setting in which they meet is familiar to neither and although they may both have some previous experiences which could contribute to familiarity, essentially, neither the student or the child feel at home in the space. They are both passing through: one as she learns and the other as he recovers.

The characteristics of children or their circumstances and what the students see at their first encounter is the next contextual condition for puzzling out connection with the child.
Children in this study:
The children in this study have been introduced in chapter three in the description of a typical ward setting. Some additional description is offered here to focus the context.

Although this curriculum is health focussed and students' clinical placements include a family, pre-school and other community based child-care settings, most of the students' journal entries revolved around their experience of working with ill and recovering children. These data therefore came from students working with children who are injured or ill in public hospital settings. Those recovering or who required care for chronic conditions were also institutionalised in smaller peripheral care settings. This means that the children they encounter are too ill to be cared for in their homes or that the families do not have the resources to care for them. The number of children with HIV-related illness is high and in the four years of the study, data increasingly indicate the presence of children with HIV related illness. Sometimes children are kept in hospital while waiting for further surgery or while they are recovering only because their families may not manage this care or live too far from the hospital to bring children to and fro for treatment.

There are three predominant languages spoken locally and students can often only speak one or two of these languages. Children admitted from recently urbanised or rural families are likely to speak only Xhosa. The number of students who speak this language varied in the student groups from 1 in 4 students to only 1 in 10. There were therefore always children who are different from the children in students' own communities, whether in terms of their language, culture and race or visibly different with their ailments or disability. Children carry their visible ailments in the obvious dressings and casts. Tubes are positioned with generous strapping to prevent these from being dislodged and the children are often more evidently restrained than are adults. Students describe the children's level of activity as very different, and see children either as desperately ill or moving about surprisingly unhampered by casts and bandages.
Another distinctive feature of wards in which the students work, is one that they
do not often recognise as unusual. It is the absence of mothers at the children’s bedside.
The presence of mothers, although not unusual, is not the norm in these hospital wards.
Mothers are therefore an addition to the context of the child, rather than a given as
described by visiting student nurses from Europe or the United Kingdom. Interestingly,
an adolescent visiting student commented enviously that, “here it must be nice to have
the children to yourself a bit more.”

A student description of children in a ward setting sets the scene for students
encountering children:

Today was my first day with sick children – a mild introduction i.e. changing nappies
(diapers), feeding and bathing. I did not find this new or difficult as I have looked after
many babies in the past. What was a challenge to me was the context of the caring. These
children were almost all here because of social implications and neglect. I was definitely
disturbed. These children should be running around in the garden making mud pies and
playing house-house but they can’t even crawl or walk. It is almost an irony that they are
here because of neglect and developmental stunting, but every one (the staff) is so busy
that they (the children) don’t even get any stimulation. Parents who have their children
here also face challenges. Most of them live far away and can’t even afford transport or
are feeling so guilty that they don’t really want to come and visit - what a vicious circle.

As students puzzle out their response to a situation in which they perceive immense
need, they are initially overwhelmed, but cope by focusing on an individual child.

Analysis of the data has revealed that there are four essential characteristics of the child
that contribute to the context of puzzling out connection with that child, these are:

- a mother is present or not
- a child attracts or does not, (either because of his attributes or actions)
- a child talks (is verbal) or not
- a child is obviously suffering, or has a poor prognosis, or is apparently better.

A discussion of each of the above characteristics follows.

1. Presence of the mother

The presence of a mother at a child’s bedside is probably the single greatest
deterrent to an approach by a student nurse. Students may relate this to something as
obvious as the mother possibly speaking a different language. The most commonly cited
explanation, however, is the students’ perception that this child has someone present to
care for him and therefore they can move on to other children who do not.
This is an early indication of the students’ sense of responsibility as causal in the process of interaction. Probing this motivation brings the additional information that the mother knows the child and the student would rather avoid feeling intimidated by her. There is the dread that the mother may require assistance or ask a question the student may not be able to answer.

And you also asked in the beginning which mothers are you afraid to speak to. I said language, but then also I find some mothers - especially I’ve notice with the children with cystic fibrosis - they know so much about it that it’s almost you feel a bit intimidated to speak to them because you don’t want to say the wrong thing. Because then they may feel insecure and think: well, this person doesn’t know as much as I do. So why should I feel safe - even with my child here? Do you know what I mean?

Data suggest that the student initially identifies with the child rather than the mother. As an adolescent, the role of child may be more familiar to her than that of parent or nurse. This is borne out by descriptions students offer of being intimidated by mothers. Students cite their lack of knowledge as a hindrance to interaction. Students’ initial encounters with children are therefore likely to be with the children without mothers around.

The child most likely to be approached by the student, despite a mother’s presence, is one who seems relatively well and contented and one who is verbal or interactive. In this situation, the student will often speak to the child to gain access to the mother. The child seems to be a safer entree, and the mother’s response to the student’s attention to her child determines the rest of the interaction.

Initially, it helps for me to have a purpose to approach the mum. Not just to arbitrarily approach her. Because I think mother could feel very threatened if you were just to stand around and start chatting to them. They’ll be wondering: what must I be saying now? What answer is she looking for? Am I doing something wrong that she's wanting to find out? I find it's easier to get to the mum through the child. You know what I mean? They can see that you are interested in their child’s wellbeing and everything. And you speak to the child. I often would then say: are you this baby's mum? And then that way start speaking to them and finding out.

This student’s explanation and expectations of the mother also reflect her own reticence about what to say next or what the correct answer to a question might be.
Students who were questioned about approaching mothers a year after their initial experience of nursing children, in their fourth and final year of study, bring an interesting perspective. These students have completed midwifery and psychiatry placements and ascribe their ease of approach to their increased understanding of the mother-child bond and the mother’s perspective and experience. Another aspect they highlight is the authority they carry as senior student nurses. They say the authority facilitates their approach to the mother. This is how one describes this aspect:

- And I think also for me, being in a more almost senior position has made it easier. You have a bit more of authority. You’re not just a nursing student, here to learn about babies or children or whatever. You have a bit more of whatever it is that you need to sometimes get the answers (to the questions) that mums might be asking.

The interesting feature of this is that the student’s motivation for interacting with the mother remains the same as when she is interacting with the child! She is puzzling out how to facilitate the relationship between them. This student indicates that the authority of her more senior role allows her access to information she could not obtain in a more junior role. She also indicates that the mother is unable to attain this knowledge. The student describes her own dilemma of exclusion from the health care team in that she is denied access to information. The position of exclusion carries with it a sense of inferiority. In the South African situation, this could be the position that mothers of sick children often occupy, due to historic disadvantages of gender, language, knowledge and therefore confidence. This emergence of authority, especially as it affects the students’ relationships, will be explored further in the discussion.

This characteristic of the presence of a mother, the understanding she has and therefore the authority concerning the child’s care is interestingly compared to a description of a father present at a child’s bedside:

- His father arrived just as I was about to change his nappy, so I asked him if he would like to do it and he said no. I did it, then asked him if he wouldn’t mind holding him while I made the cot. He was so unsure that I got him a chair and put his son on his lap. He proceeded to sit with him for at least an hour. The child is HIV+ and perhaps he just wasn’t sure what to do with him – the child is ill but looks reasonably healthy. He also has a gastrostomy which I suppose looks quite frightening and he may have been afraid of hurting him.
Unless the student feels very uncertain of the father, this is a typical response to a father. It seems that there is an assumption that they will “not know what to do with the child”. This puts the student at ease and “in the know”. It may be that “knowing” affords them authority in the situation and they are less afraid to approach and facilitate the father’s interaction with the child. This quality of “knowing” has emerged from analysis as a causal condition to the basic social process of puzzling out connection. In the above example, the context is defined by the presence of a parent, who in this case is a father and the student’s conclusion that she “knows” causes her to connect in a certain way. “Knowing” as a causal condition is more fully described in the findings.

There is another situation in which a student may speak to the mother (the adult) first, and then rely on the mother to communicate with the child. This occurs in the context of a student who does not like children or feels that she is unable to communicate with a child. The student will either not interact with the child or connect by speaking to the present mother.

- Student: I think what made ICU easier for me is that a lot of the children are unconscious. So it's more just ordinary care. Not so much communication between you!
  Researcher: So you didn't feel like you had to connect.
  Student: No.
  Researcher: Was that a pressure in other places?
  Student: Ja (yes), I think so. And I found it a lot easier... I got on well with the mothers in ICU. I mean that's what I miss, it was the relationships I built with the mothers - rather than the relationships I built with the children.

It is only as students’ confidence grows that they vary their approach to connecting with a child whose mother is present. This confidence is then counted as a resource and they are willing to adapt to individual children. Yet, this does not mean that mothers are always welcomed. A student in her fourth year says:

- For me this week it's something that has stood out completely. I mean there are always parents around. And it's like you're working in adult nursing and sometimes you feel like saying: oh it's not visiting hours now! You know...like shoo them out of the ward! But you can't do that because the parents are entitled to be there - whether it's the grandparents. Like there will be one child and there will be three people standing around the cot-side.
Students also puzzle over and compare children and their behaviours with and without their mothers. They were often observed contemplating which is better for the child and for themselves.

And also one thing that I've noticed with children whose parents aren't there: they are either like Cal, very reserved and quiet, or they are the complete opposite. They are the ones who love the nurses and follow you around and want to play the whole time. More so than the children whose parents are there.

It is often these two groups of little ones who compete for the attention of caregivers: those who attract by giving attention to the nurses and following them around, and those who attract attention by their quiet reticence. This brings the discussion to the child's characteristic of attracting.

2. A child who attracts

Initially the cause of an encounter may be that the student is assigned to work with a particular child or children. It is clear, though, that students often choose the children with whom they work. Reasons students offered for their choices vary from the fact that the child was 'so cute' to 'he looked so helpless'. Descriptions of encounters with specific children are a consistent feature of student writing. I often asked “Why this particular child?” or “What attracted you to this child?” Students’ reasons were often that these children were “irresistible”. The students therefore clearly place the onus of the attraction on the child and this is why it has emerged as a characteristic of the child rather than the student. The motivation for relating to specific children could help one understand why reports show that some children in hospital can spend a great deal of time alone. They may be those not cute enough or not willing to compete to be noticed.

She was very successful at getting my attention, because she was this lively little girl who is willing to compete to be noticed. So much the opposite of one little boy who was quiet, reserved and didn’t want to laugh or play with me. Even Tom (a male student) tried to get his attention, to no avail. The two of them really opened my eyes to the difference between children and the differences in myself towards them. I found that I preferred to be with the little girl, she was so much easier to be with.

Focused data gathering and observation revealed that the child’s gender is not often an attracting factor, although, students may use the child’s gender to understand a behaviour trait. After this previous quote the student does some reflecting:
I think the reason why Lundi (girl) was so much more alive and mature than this boy, is because little girls are more mature, by nature, to boys of similar age. This point of view makes it easier for me to understand and not feel a failure. It was a worthwhile experience to have gone through.

Here the student's understanding adds to the importance students place on successful encounter. Succeeding in this encounter prevented the student from feeling a failure. Choosing the cute and engaging child therefore sets a context for successful interaction and this in turn offers a context for puzzling, understanding and learning, as the next student indicates:

I have met the cutest, most adorable child. He's 3½ yrs and his name is Jonah. He rides his tricycle with his friends up and down the passage. My relationship with him has helped me understand certain things about children such as temper tantrums, tearfulness and children's coping mechanisms.

A child who is not described as cute is more likely to be called a "challenge". Once again the student will be drawn to the child in an attempt to work at a connection with the child and the data is full of examples of these little ones drawing students. They are described as scruffy, often ill, and often requiring additional physical care. They may have a sore mouth or a severe nappy rash and often have intravenous (IV) lines and special feeding requirements. It seems that these children attract in that they require care by touching and doing rather than by relating. Students often describe these children as "neglected" and hence the challenge to spend time with them is justified. The rewards are similar to those of relating to a cute child: a successful encounter, which often has a measurable outcome. This outcome may be a clean mouth, shining with lubricating ointment or a feed slowly and successfully completed. It is almost as if they aim to leave the child more attracting than when they encountered him.

I am certainly not attracted to children on the basis of gender, eyes, cuteness etc but rather children who are intellectually stimulating for me and where I can see progress being made.

Another attraction is a child calling or crying. It may not be what is usually described as attracting, but what the child communicates to the student in a cry differs, and is of course related to the student's own context. As a student described earlier, her motivation for picking up a child is not to cuddle but to quieten the child. Whatever motivated the student, the child succeeded in attracting her attention.
It is clear from the data that students are less able or willing to leave a calling child than are staff, who have been working with children for longer periods of time. Students recognise this and although some become angry with staff members, others see it as a way of coping:

- Nursing children must be very taxing for staff because it is such a giving relationship. Constant hugging, loving, cuddling, caring and not much in return. It must be quite easy to just clam up and protect yourself by becoming hard. P3.3, journal.doc 80-83

Another aspect of calling, which attracts students, is when children remember their names and welcome them to the ward in greeting. Some children will call a specific student, making a deep and lasting impression:

- I remember seeing him (5 year old) for the first time in the corner sitting straight up just looking at everyone in the ICU. I just remember looking at him from a distance wanting so much to know just what is wrong with him. While I was still looking at him he called me to come to him. I looked around wondering if it was really me he was calling because after all I was a total stranger to him. I went over to him and his exact words to me were. "Hello, are you going to wash me, cause I want you to" From that moment on I fell “in love” with him. I mean, here this child was half out of breath wanting to know if I, a total stranger, would wash him. P4.5 narrative.doc

Once a child has attracted a student in this way, it is often difficult for the student not to be with the child.

- She held my hand for the rest of the day and would not let anyone sit next to me. We sat in a circle and sang songs and anyone who tried to take her place next to me was quickly put out of the way. P4.15 Nar.doc 32-35

Students are ambivalent about their emotional attraction to children. Some students welcome it and it flatters them. Others try to understand it or justify the attraction they are feeling. In their developmental phase, professionally as well as personally, this may be why students ascribe the responsibility for being attracting to the children. The emotions attached to feeling deeply are not always welcomed, as students often voice the concern that they are being “unprofessional”.

- I worked in the urology cubicle. Bigger children are more observant. I was standing between two beds on the one side and this other child said I don't love him. I didn't notice that I have been doing that, it just happened that I just kept on going to stand that side. Later the child asked me to come and stand next to his bed. It really felt bad because I didn't want to prefer or favour one of them. He said to me I must stand next to his bed for the afternoon, but that was impossible. P1.8 W4codat.doc 1143 - 1157
The question of having favourite children is viewed differently by different students and could cause some to avoid spending time with a certain child no matter how attracted they were to that child. Other students just do not find any children attracting and the onus of connecting is then left with the child:

Researcher: Did you never find a child cute?
Student: Not really!
Student peer: Did you ever find a child that you wanted to connect with?
Student: No, I don't think I've ever found one that I wanted. I mean I find some of them easier to connect with because they would come to me. You get some children who are like that; they just follow you around and they're just following you all the time.

3. A child who talks

The child's ability to talk emerged as an important quality, when data revealed that the ability to communicate with children was a pervading concern for students starting to nurse children.

I really try to avoid infants or anyone that cannot speak yet. It is very difficult to communicate to them. They usually look at me as if they do not trust me. I am often scared that a child will cry and that upsets me.

As the data gathering and analysis progressed it became evident that verbal ability was a qualifying characteristic of the children whom students encounter.

I thought that it was going to be a pleasure to work with the bigger children because they'd understand what I'm saying and they will be able to respond and all that. It was just so absolutely frustrating trying to discipline them. And that actually made that I didn't enjoy it as much as I did working with the babies, in the end I actually preferred working with the babies.

As the child’s verbal ability is important to students, so too is his ability to understand verbal communication. The issue of language becomes a really important one. As described earlier, there are predominantly three languages spoken in the area. The students add another one to this: baby language.

In the beginning I felt as if I couldn't talk to the babies. I felt silly when I had to speak to them in that language But now I've learned how.” I understand where they are and how they are thinking. I don't think they understand the language, I think they understand more the tone.”
Talking to and understanding infants is a recurrent theme in the data and whenever it is mentioned, students refer to it as their ‘language’. The pressure experienced by students to learn it, caused frustration similar to that experienced around other languages spoken, but not understood by students.

The ability to speak the child’s language is clearly an important contextual condition in the encounter with a child. This student and child both spoke Xhosa.

✓ I have established a very good relationship with Khanyisa. [It’s] simple because we understand each other very well because he could understand my language and I understand his.  

A child’s verbal ability influences the encounter even if the language spoken is not the same, increasing the possibility for communication.

❑ There is a new little boy (7yrs) that has taken a lot of my time. He is in end-stage AIDS and his mother just died of AIDS in January. He is completely institutionalised and although he speaks no English and I no Xhosa - we communicate very roughly. At eleven o’clock he knows that he gets juice and biscuits and should you forget - you will be reminded.

This child required additional care being terminally ill. As was often evident in this study, the student and the child made a plan between themselves and played their best game despite significant odds.

4. A suffering or dying child

❑ When I work with dying children I am filled with a type of horror...it is just so unfair! I grew up playing in the garden, with mud pies and with all my animals, these children have grown up in hospital with I.V lines and naso-gastric tubes and pain and terror as their friends. And it does have an effect.

These were the student’s thoughts directly following the previous quote, but despite her horror she persists in puzzling out connection with this child. Later in her journal we read about the same terminally ill seven-year-old boy:

❑ Everyone puts nappies on him, then when he wants to go to the loo, he can’t get the nappy off and then makes a huge mess. On the ward round I explained to all the staff what I thought the problem was and they agreed to give it a try. It has worked like a charm. No mess in the bed anymore!
This example shows a student persisting with a child, despite the terminal illness he has and which characterizes him. It is clearly a contextual condition in the encounter with the child.

Students have different ways of gauging the child’s illness, and these are noticeable throughout the data. They may refer to a child’s “thick folder” – volumes of hospital records clearly indicate complicated, lengthy or repeated hospitalisation. Some students will delve into the records with alacrity, while others will rather approach the child before seeking more information about his condition. An initial fascination with information, however, often leads a student to the child, as she seeks to understand or merely wants to “see what it looks like”. Visible ailments and afflictions are often described with horror, and students vacillate between wanting to see and trying to cover manifestations of the child’s pain, eg. burn scars. Working with little ones who have suffered burns is probably one of the most difficult of these situations. This kind of injury also brings the inevitable and very difficult question of the reasons and fairness for a child’s suffering. The questioning inevitably extends to terminal illness in children, and students often submit cases of suffering to fairness as they try to work out their responses and puzzle out connection.

And it’s just so sad, and you want to help them. The worst for me was when I worked in ICU and we had one little girl with liver cancer. Totally on life support, and eventually they had to switch the respirator off. Ja, and it wasn’t like it was a car accident or something that you can sort of put a reason behind. She was 3-years-old. And you sit for 10 minutes and watch her gasping for air. It’s like you know there’s no purpose behind this at all.

The context of the encounter with the child is clearly influenced by the child’s condition and the student’s motivation to help, to make it better for the child in some way she knows:

But it’s so difficult when you’re going into a place and you’re seeing a child that’s unconscious on a bed or something...You are confronted with the baby, and you’re not really allowed to pick that child up. How do you love that child? In terms of caring for that child? And I think that is the difference. If my nephew cries I pick him up and I carry him around.

A child who is obviously suffering and has a poor prognosis considerably complicates the encounter for the student. This situation is becoming more and more common as children with HIV-related illnesses are nursed in hospitals.
The persistent rejection experienced by folk with a positive HIV diagnosis, also means
that these terminally ill children are more likely to be in hospital, than dying at home
with family.

Encountering little ones who are terminally ill with an infectious disease adds
another dimension: fear of infection or cross infection:

I came home tonight feeling that I needed to strip down and disinfect my clothes with
the strongest disinfectant I could find. I took a shower and still felt that I needed to scrub
a bit more here and use much more soap there. It was absolutely “grilerig” [causing one to
shiver or flinch ] to work with children with AIDS. I forced myself to touch their wart
covered bodies and to clean their eyes. I forced myself to touch their skins which was
covered with candida. And all the while I knew that I couldn’t contract AIDS by touching
them. I think it was more the sight of thirty to forty warts occupying the sacral area of a
little girl that scared me. I could almost not bring myself to touch her face (+- 20-35 warts
covered her chin). What made it worse was seeing small amounts of pus in the center of
some of the warts. The babies had small but numerous open sores on their genitalia and
often had excoriated skin around the anal area. Their skins were dry, almost scaly and
those who had candida looked like flakes of dandruff. Whenever I’d lift their vests tiny
flakes would fall to the ground. In spite of all this they looked happy.
My reaction towards the children amazed me. I have worked with adults whose AIDS has
progressed so far that they were literally waiting for death to settle upon them. Not once
have I felt that I couldn’t touch them and not once has the thought that I could contract
AIDS through them scared me. I think that today I actually began to understand a little
bit of what some people feel towards people with AIDS and its very disturbing. I watched
my friend (another student) as she kissed one of the babies and how she stuck her finger in
his mouth and I just felt that I couldn’t do it. And I didn’t.

This honest description of a student’s experience is offered here to capture the real
difficulty of interacting with children visibly ill with this infectious and dreaded disease.
Little ones with HIV-related conditions are often those described as “challenging” and
students do admit to avoiding them. Sometimes the challenge is just too great and their
resources too limited. There are, however, occasions when they face the challenge with
what can only be described as youthful courage.

Their motivation to connect with the child is, as has already been described, the
motivation to make a difference to this one child. This is part of the energy they bring as
adolescent and ‘new’ carers. Their determination and care is sometimes frowned upon
by older colleagues, doctors and nurses alike, who may be the ones who carry a larger
and different responsibility for each child.
This student reports the intensity of her experience as she is assigned to care for one terminally ill child for the whole day, not a common occurrence in an under-resourced ward:

Today I was assigned to care for a little girl of 4 years old who is dying of AIDS. I felt quite challenged at being given this responsibility but I enjoy one to one contact with the children and this would enable me to spend time with one child without feeling guilty for it.

After spending the whole day caring for this little girl, often just sitting with her and holding her hand, the student described the following...

All the Prof's and consultants came in that evening while I was sitting at her bedside they were all giving guesses as to how long she would live for - it was as if they were betting on a horse race not the life of a child. They all looked at me cynically and said "do you know the protocol for these kids?". I was deeply saddened at their approach - they presumed that because I was giving this child love and care, that I would expect them to jump in to resuscitate her when she died.

The passion evident in this description is not uncommon as these young people pour themselves into the care of children in conditions of suffering. Reticence or caution from older colleagues about investing in these children is more likely to motivate than deter students. A week later the same student writes about the same four year old:

I washed her and rubbed baby lotion into her dry skin and she seemed so much more responsive and had more life in her than last week. She moved her limbs herself and actually tried to smile a few times. I cleaned her mouth and generally just made her more comfortable - it was wonderful to see her not gasping for every breath and hanging onto the oxygen pipe.

Later on in the day I went to see how she was and she actually raised her arms as if she wanted me to hold her. This is something which I have wanted to do since I began nursing her and I was so touched that it was her who initiated it. I picked her up and held her close to me for a few minutes. It was such a special feeling to be able to care for someone so completely with your whole person. Seeing her this receptive also made me very tearful because one of my most vivid memories from the oncology wards is that people often have a burst of energy or new life before they die... when she held her arms out to me I had the same fear that I shouldn't get my hopes up because the reality is that she is dying.

This discussion of the child and related contextual conditions began with the statement that the child who was most likely not to be approached by the student was the child whose mother is present. There is a condition which further complicates this situation, and that is approaching the mother of a dying child.
Researcher: How do you talk to the mothers whose children are dying?
Student: It's difficult to sort of go there.
Researcher: Because what will you say?
Student: Because you feel that the child is in the hospital to get better and not to die, and so maybe you are not doing the right thing.

Most students avoid this situation at all costs. They defer all responsibility for interaction to more senior staff. In all four student groups covered by this research, there is only one description of a student who ventured into this domain of interaction. She describes having to find the courage, and her motivation was strongly influenced by her commitment to the child whose mother had not been in the ward for the last three weeks.

Her mother suddenly burst into tears and hid her face with her arm. I put my hand on her arm and just sat quietly for a while and let her cry. It was such a strange situation seeing the little girl sitting on her mother's lap looking up and seeing her mother crying and then turning around and looking at me. I felt a deep longing to understand this mother's grief, sadness and despair. This woman I was looking at is struggling with her own HIV status as well as her daughter's and the knowledge that she "gave" the illness to her daughter. After a few minutes of silence - which I felt comfortable with...she said "she is getting better now". I didn't know how to respond because I so desperately wanted to say "yes, she is"... I said that she had started improving since her admission and was getting stronger but that she is still very sick and that it was OK for her to feel sad and cry. I sat with them for a while longer and then said to her that she could call me during the course of the day...The language barrier was a definite limitation in my interaction with this mother. She was not free to express her feelings because she knew I would not understand her and I was not sure what to say because I knew that she would not understand me. I hope that she was able to receive my genuine concern without feeling too threatened and intruded on. This time spent with this child and her mother, although emotionally difficult was important for my general understanding of the mother-child relationship and overall complexity of the situation.

As this data portion so clearly illustrates, the contextual conditions which the characteristics of the child bring to the student who is puzzling out connection, can be identified, but these are thoroughly woven into each interaction. The presence of the mother, the attraction of the child, the communication between them and the nature of the child’s illness are all key strands in the richly woven context.

The purpose of this section was to describe the context which the student and the child bring to the process of their interaction and thus to the student's learning in this setting. Although the student's actions and interactions are more fully described in the following section, these have been woven into this section to give the reader a taste of the complex context in which this learning or central phenomenon of puzzling out connection occurs.
Section 3: **Intervening conditions**

Intervening conditions are the conditions which essentially help or hinder the students in the process of puzzling out connection. The previous section described the student and the child as the foundation of the context of this social process. The conditions that have emerged from the analysis as the intervening conditions, are those that affect the process of puzzling out within this fundamental context. The two major categories distilled as intervening conditions are *remembering* and *others present*. These two conditions affect the basic social process in identifiable ways at various stages. The following description of these two conditions will clarify these effects.

\[
\text{Anticipation } \rightarrow \text{ encounter } \rightarrow \text{ connection}
\]

- **Remembering**
  - by comparing
  - & finding the rules

- **Others present**
  - by clarifying expectations
  - & eliciting support

3.1 Remembering

*Remembering* is what happens when a situation arises that causes a student to think about something in her experience, something that she can relate to the current occurrence. It often happens in the context of uncertainty or when needing to make sense of a current situation. *Remembering* is the condition describing how students think about and utilise their own previous life experience. Remembering may inform an action or allow a conclusion to be drawn, and this influences how the student puzzles out a connection. The aspects of remembering that are most relevant to the students learning are *comparing* and *forming rules*. These are best evidenced in what they remember or utilise as they puzzle out their actions.
The aspect of needing to make sense of a situation often triggers remembering. A trigger could be an incident or merely the topic of a conversation. Students often have and therefore talk about common experiences like being ill, being hospitalised or how they were disciplined as children. Experiences associated with strong emotion are more likely to trigger remembering. Students may recognise a memory trigger suddenly and consciously, or the trigger may be a subconscious awareness. One student was left handed, and spontaneously asked these questions while watching someone demonstrate a skill:

© “Why is the child’s one hand restrained?” He was asking because the child’s right hand was restrained and not the left. “Does preference (left or right handed) occur by one year?” “Why only restrain one hand?”

The students’ experiences in their own families certainly affect their ability, and sometimes willingness, to remember. The data reveals some specific factors related to families that may facilitate or suppress students’ remembering. I recognise that it is difficult to measure or track this cognitive process of remembering. The descriptions and conclusions in this section are therefore based only on evidence in the data that reveals students consistent use of this process.

One of the first factors related to students’ own families is their sense of belonging. This includes how involved or absent the family members, especially parents, were, as well as whether their experience of family was positive or negative. Here is a glimpse of one student’s family experience:

Ω Some of the memories from my childhood are good, but others are locked away where they can’t get out and haunt me. Many things from my past aren’t resolved but I’d rather not take the risk of getting hurt by thinking and talking about them.

This student sets out choosing not to remember, but the intricacy of what elicits memory often overrides choice. In this case the student proceeded through the initial weeks of her learning experience articulating her experiences carefully in her journal. Her family experience appeared to have been shelved in a hidden place. Twelve weeks later she was on duty when a little one who had been abused by his mother’s boyfriend required her care in a surgical intensive care unit and then she remembered. Even if she had been able to suspend her memory to this point, remembering now became an influencing factor in how she puzzles out a connection with this nine year old boy.
Aspects of the student’s family that could affect remembering include: siblings, their age range and the student’s position in the family (eldest or youngest).

As I approach paediatric nursing, I feel rather nervous and scared. I have had such a little experience with children. I have never had cousins or extended family. I guess my only contact has been with my brothers.

This example indicates how remembering can be an influencing factor in the anticipation phase of puzzling out connection.

Living in an extended family affords the student greater experience of families and increase triggers to remembering. Students often indicate the numbers of present or involved relatives, aunts, uncles, cousins and grandparents.

As we (teacher with student) put the child into the straight corner of the box, which I suggested to help him to sit upright and increase his balance, there was sudden recognition from the student. She said: 'Oh I remember my granny used to put us in a corner on a potty.' I asked whether she could remember when that was. She said she didn’t know whether they couldn’t sit, or whether that just meant they couldn’t move. But she is going to ask her granny.

Experience of other people’s children while growing up also increases students’ experience base. The nature and regularity of this contact are contributory factors. Some students in this study reported a variety of experiences with children outside their family, while others have very little or no such experience. Activities range from babysitting to community service e.g. leading Brownies and teaching younger children subjects like mathematics, religious instruction and piano lessons at a local children’s home.

My experience of children has mostly been through my little cousins. I seem to acquire cousins every ± 2 years. They drive me crazy at times but I don’t regret having them in my life.... I sometimes feel as if I have very little patience with other people's children but I am sure that I will be different once I have children of my own.

As indicated, the central aspects of remembering are comparing and finding the rules. Students may compare the situation at hand either with their own experience of childhood, or that of their siblings and friends’ siblings.
What I (researcher) notice with this student, is that she constantly refers her current learning to her own experience as a child. When I pointed out that the child has eczema, she said: "'Oh, eczema! You know, I get it right behind my knee.' And the more she asked me what it was and how it worked and was treated, she said: 'oh, I still get it.' And I realised that even as I was explaining about the child, she had difficulty moving from herself to the child.

Students also often refer in anticipation to their own future children and parenting of these children (none of the students had their own children at the time of their participation in the study).

Students use comparison as they encounter different settings or places. Initially they compare adult hospitals with children's hospitals or children at home to those in hospital. They compare not only the structures but also the atmosphere.

Researcher: What was different about starting with children? Nursing children?
Student 1: I think it's the setting. Not being in the house. I think it was the setting that was different. The atmosphere basically was different. We started at a place where the children were up and about. It was just like they'd be at home. The difference was that they were ill. You know, but the illness that they had wasn't as if they were bedridden or anything. It's the setting, the atmosphere.

Comparison is also used to understand different conditions or diseases. They compare how illnesses present differently from the condition in someone else they knew. Students compare their or another's experience of a situation in order to improve understanding of the same condition in a child who cannot articulate the experience. Comparing also assists them with checking the beliefs they hold or validating their stance:

"I always thought they cry" or "I still do not like babies."

Remembering rules is the second aspect of remembering. It seems that once they have recognised or made sense of a current situation by remembering a similar incident it brings a measure of safety to an experience. Data suggests that puzzling out can cease or need not be pursued.

The student asked why it was that the children were allowed to play outside today. And I (researcher) thought that was a strange question, until she said: 'But it is cold outside. Then she said that at the Educare Centre where she normally helps, the children are never allowed outside when it is cloudy. I asked: 'Only when it is cloudy, not necessarily when it cold or rains?' She said: 'No, when it is overcast or cloudy they are not allowed outside.
It was difficult for this student to puzzle out the reasons for a rule she knows and has accepted. If she had not asked, her remembering the rule would have resulted in applying it without questioning in various situations. It is clear that students rely on the safety of rules. These include the rules and values according to which they were brought up. The rules students formulate in these settings may be similar to the rules in their experience, or they could formulate new rules for themselves. This happens if they do not agree with a rule they remember.

As students remember they make a connection between current and known information.

- We (small group with researcher) then went through the three-month-old’s development noting how she had progressed from being unable to control her neck and head. This they said they remembered from working with new-borns at midwife obstetric units.

As previously indicated, remembering could be an influencing condition in any of the phases of the process of puzzling out connection. Here it affects the student’s phase of anticipation and the student’s encounter with the child or setting.

I was feeling quite despondent this morning about working in the rigid environment of a hospital again. I find the strict routine and intimidating hierarchy very restricting. We began the day by feeding the babies (all the children in my ward are under one so they all get bottle feeds). I enjoyed being with the children again and getting to know new faces.

Remembering sometimes results in sudden recognition and this could become causal in puzzling out anew or remembering something else.

Things have been going well … surprisingly, as children and babies are not - or rather were not - my favourites for the past few years. I thought that I would be irritated by them and wouldn’t have the patience, but I do have, I find. They can be tiring though and I have realised that one should set limits for both yourself and the children.
3.2. Others present

This is the second category that has emerged as a major intervening condition for students as they puzzle out how to connect with children.

In being a learner and being new to a situation, the presence of others is a key intervening condition. As has been stated, an understanding which emerged early in this study has been that learning occurs in the context of relationships with others. The nearness of others influences the student's learning to be with children by guiding the student in the unknown of being with children. These others may include any significant others: teacher, peers, or ward-based nurses and other staff. Students' own families could be included, but lack of current proximity moves their influence mainly to the category of remembering.

As students describe the nearness of others in their puzzling they indicate that:

• peers know what it feels like and are present

• staff know the routine and the rules but their expectations are not always clear and have to be discerned. They also often do things differently from the way in which the students are taught to do them.

• the teacher or clinical tutor knows a lot but in the clinical setting is not always near enough

As students are puzzling out connection with children, others' experience and nearness to the situation have emerged as important. What others are able to do, as well as how much they know, are relevant.

Students initially rely on the unit staff, mostly experienced nurses, as their immediate help. In the early stages of placements with children, they rely more on what they see those present doing, than on what they may have learned in the class setting or know from their own experience. This may change as the students' confidence grows, but does not always change.
The teacher or clinical tutor’s influence is only referred to when she is present. It would appear that it is only when the tactics of the most consistently present carers (unit staff) are not seen to be “working” that the student will seek back-up or alternative approaches. Remembering, as the other emergent intervening condition, is then apparent. The student remembers previous experience, tactics discussed in the classroom or seeks peer consensus. The students in the research setting almost always work with at least one of their peers. Peer presence contributes to learning in the important area of knowing: particularly knowing “what it feels like”, as opposed to necessarily always knowing the required information or technique.

Initial analysis yielded four categories describing relationships which influence student learning: relationships with peers, with the teacher, with unit nurses and staff, and relationship with the child. Focused data gathering and further analysis revealed that the first three were intervening conditions and the last a contextual condition in the central phenomenon of student learning called puzzling out connection.

What is it about other people that is significant in this learning? Data revealed that it is not only that the students are in relationship with others, but that these others are near or present. Others present therefore emerged from the first three categories. Presence or nearness implies proximity and accessibility: not far away from the student but near at hand, even within earshot. While those present may affect a student’s puzzling out in different ways, the nearness of others influences how students clarify expectations and perceive support in the situation.

3.2.1 Expectations of others present

The first property of others present is that of expectation. This includes both expectations students have and also those they assume others have of them. It is clear that students have pre-determined expectations of unit staff. Students do not always communicate their expectations clearly. In their own and the staff’s defence, they often indicate that there is no time and therefore little opportunity for this. As they then go about puzzling out how best to do things, they tend to work out how they need to engage with a child to maintain relationship or cause the child the least distress.
Whilst working out how to avoid waking a child or making a child cry, they expect those present (the staff) to have the same goals.

The second aspect of expectations is therefore that students expect that there are "rules" that will help them accomplish desirable outcomes. As they try to identify the rules, they often ask staff for the ward routine and sometimes for the policies and procedure manuals. This search for the "rules" is similar to that seen in remembering. The game rules clarify the players' expectations. Once the rules are established, the game can flow with less effort and more attention to winning. Winning for the students is successful completion of tasks or connecting with a child, or seeing extra effort pay off in some way.

One student describes her second afternoon in a new ward:

- This was a very busy day, the morning was better but in the afternoon we were few. My classmate went off after lunch and the staff I was working with seemed to panic not because we were few but they have a fear that we won't finish the job before 19h00. I do not like that idea when I am working because it makes me to rush and make mistakes. I also had a lot of pressure from my work team as they kept saying do this and do that as if I am lazy...

Three weeks later she describes the same ward:

- We had a busy Monday right from the beginning as is often the case in the gastro side... Working with children is beginning to be enjoyable these days. I think many factors add to this, for instance I now know the ward routine, I also know that actually my team mates are not trying to be funny to me but just teasing or helping.... We worked very well today and no one was panicking even when we had 3 admissions at 18h00 we helped one another to get done before 19h00.

Expectations of peers are interestingly consistent: they are expected to share knowledge and work alongside wherever possible. When the relationship between peers who are working together is not comfortable, competition tends to colour expectations. Despite instances of this, the data indicates a tolerance of peer nearness. The two students in this excerpt were friends and worked together. One had previous experience with children and the other did not. The former (student 1) spoke often of her friend's awkwardness and told the stories with glee.
Expectations of the teacher in this study were also consistent throughout the four student groups. Their expectations of the teacher were more likely to be for support and presence than knowledge. They clearly rely more on the teacher’s experiential knowledge than what she would teach from theory.

3.2.2 Support from others present

The second property of others present is the support students elicit from them. Support is sought by the students as they seek confirmation of their actions and emotional support and as they pace their own practice. Students seemed to perceive two dimensions to the presence of others:

- reassuring $\rightarrow$ intimidating
- inclusive $\rightarrow$ exclusive

Others present may convey a message of reassurance or the presence may be intimidating. The student’s perception of the message, and how she receives it, are key in how it influences the puzzling out or actions she chooses. A recurrent theme in the data regarding the presence of others is whether presence is inclusive or exclusive of the student. Both these dimensions of others’ presence influenced how the student recognised and could rely on the support.

The worst possible thing I thought could happen on my first day there was an inability to get on with staff. But the warm acceptance from the sister-in-charge, good relationship I maintain and their willingness to teach was really helpful.

Support from the staff was a recurring theme in the data. In the previous example of staff presence (P3.9 Journal.doc 206 –220) the student indicates how her perception of staff presence changes.
Her perception changes from others excluding her by giving instructions and scolding, to the team becoming inclusive and helping one another. Her experience of the other dimension ranging from reassurance to intimidation is also evident in this description. She speaks about *needing to rush and being under a lot of pressure*. She clarifies this in her journal and adds that it would have been helpful if they had appreciated her small contribution, rather than criticising her. As she becomes part of the team and moves from being excluded to included she becomes supported and a supporter. She describes how they help one another to finish the work, rather than “I helped them.”

The perception of whether a student is part of a team or not, is an important influencing factor in her puzzling out. This is well illustrated in the event of being delegated a task. An example of this is being sent out of the ward, to accompany a child to or from the x-ray department. If a student perceives herself as a team member, the message of support she receives is: “I am trusted”. If, however, she does not feel part of the team, being sent away is easily interpreted as “I am dispensable”. This indicates a reciprocity of support: If the student is supported, she acts as supporter of the team. If not, the absence from the ward may even be prolonged by a visit to a friend in another department, thus lengthening her absence and not supporting the remaining team or the child waiting in the x-ray department.

Various aspects of peer nearness influence puzzling and engaging with children at different times. These include students checking their interpretation of a situation, measuring their progress and doing something alongside another. Concern for a peer is a common feature in this situation where students intimately share the demands and stresses of learning about children. In situations where one student feels unable to support another adequately, she often seeks additional support. She may, for example, approach the teacher and ask her to “attend” to a struggling peer.

The property of support, not only as students begin, but also as they continue to engage with children, remains a key intervening condition. Support of others, peers, teacher, own family and staff remains key in facilitating or constraining students as they puzzle out how to connect with children.
Section 4: Causal conditions

There are two central conditions which cause students to work out or wonder about their actions as they connect with children. These are, firstly, how they perceive their responsibility in the situation and secondly, their knowing what they need either as information or in terms of ability.

responsibility and knowing

Anticipation → encounter → connecting strategies

The emergence of these as causal conditions in students' puzzling out how best to nurse children are probably the essence of what every fledgling player considers in learning a new game.

4.1. Responsibility

Responsibility is present from the earliest portions of the data and therefore in the students' earliest experiences. Students' descriptions of their anticipation, their encounters and their actions are peppered with their sense of responsibility. They often describe children as dependent and anticipate the implications of this dependence for themselves:

Working with babies is not my idea of fun. I don't enjoy the nappy changes, feeding them (especially if they take half an hour to chew one teaspoon of food), talking to them or the fact that they display a helplessness and therefore dependency on you. I am of course hoping that all this (my attitude) will change in due time and that my approach towards them will be more positive. My main reason for this is that I realise just how helpless, dependent and needful they are.

P3.4 journ.doc 2-9
In the phase of anticipation, the responsibility could cause either dread or be perceived as challenge. The above shows how it causes the student to puzzle out, not only how she would manage to do it (i.e. this activity of nursing babies), but also how she would connect with babies. There are aspects of the puzzling out that are related to herself and what she does not like. Some students have a strong, innate sense of responsibility. This is often seen in these student groups. If students like children their response may be different but the experience of responsibility remains. Not unlike the dread that the responsibility brings, positive expectation linked to responsibility also causes students to puzzle out their actions and interactions with children.

• Initially I find that I was a bit apprehensive because I love children, but I didn't know what it was going to be like to care for a child in a hospital. Especially if it's a very sick child. All my nieces and nephews that I'm surrounded with are very healthy. So I don't know how it feels to have sick children around me. Besides myself when I was ill; that's the only experience I have.

Students describe what elicits their sense of responsibility, how they feel about having to assume it and whether they want to carry it or not. They also ask the question of who should carry the responsibility for a child - does it belong to the nursing staff, especially the more senior staff, or does it really belong with the mother?

This condition of responsibility, that causes the student to puzzle out her action and interaction with the child as it influences how she connects, will be tapped by these four questions.

• What elicits their feeling of responsibility and when do they recognise it?
• How they feel about having it?
• Do they assume responsibility with certain children or not and what affects this?
• Who should have the responsibility - is it the other staff's, especially the more senior staff, or does it really belong with the mother?
4.1.1 What elicits their feeling of responsibility and when do they recognise it?

As already indicated, the initial understanding that children are dependent and therefore require more vigilance is encountered early in the data.

I have 2 nieces and 1 nephew. They are 9, 7 and 5 years old. They are very nice children but they are wild. They drain my energy when they come over to visit. They are very restless and one has to constantly check out what they are doing because they can easily hurt themselves.

It is interesting that even though these children are known by the student and are verbal, well and in a familiar environment, she perceives that they require much vigilance.

Safety of children is a common concern eliciting responsibility from students. A code note during initial analysis (dated March 1995) asks the question:

"Is the concern about safety related to responsibility?"

Students are more likely to speak of their concern for a child’s safety than to call it a responsibility. Confirmation that their sense of responsibility is a causal condition to puzzling out is that a concern for a child’s safety is often given in response to a question from the teacher like: “Help me to understand why you decided to do it that way?”

Honesty is an often-mentioned feature of children, especially as students describe how they differ from adults. This is usually something they cite as liking about children but which confers added responsibility on their careers:

With children; they never lie. They are so honest, they just tell you what they think. And it's always the best to know what they think because then you know how to care for them. You know how to see to their needs.

All the above factors which elicit responsibility, are related to what the student anticipates or recognises in a child; their dependence, their need to be kept safe and their honesty. Seeing a child who needs tending, an ill or weak looking child or one who is alone, is most likely to elicit the student’s sense of responsibility:

I was wondering why this tiny baby, lying on his stomach was permanently rubbing his nose against the mattress. I picked him up and saw that he had nasal prongs (oxygen) which must have irritated him. He was on oxygen because of having contracted pneumonia. Norman liked to be held in my arms and looked at me with big eyes. He looked as if he was to say “Sure, can you believe it, somebody actually picks me up and talks to me.”... The main reason why I had picked up Norman was his cry and discomfort.... I just felt so sorry for this little helpless being, which seemed to benefit so much from just being held in my arms. I changed his nappy and gave him his bottle and that is how the story begins!
This student goes on to tell the story of her relationship with this 4 month old who weighed 1.9kg when they first met. The causal condition here is clearly her response to an apparently untended baby's discomfort. It starts her puzzling out how to connect and make it better for this little one. Later she says:

- I never saw anybody of his family popping in and holding him.... Norman is such a lovely little boy and I really find it hard to distance myself from the whole problem. He observes everything that one does and he is very relaxed when being held.... I do not know whether something like bonding between Norman and me occurred but I definitely feel attracted to him as a caregiver. One of the reasons might be that he responds to my talking. He does not smile, which might be expecting a little bit too much and maybe he already is mistrusting everybody because there is nobody constantly with him.

So students demonstrate their willingness to respond to their understanding or experience of responsibility for the children they encounter. This leads to the next question.

4.1.2. How do they feel about having responsibility?

Students are ambivalent about assuming responsibility. While sometimes willing, they are not always ready to take it on. This may not be unexpected of adolescents' willingness to take on challenge. It adds to the context in which puzzling out occurs. If students feel as if they have been assigned the responsibility, they often assume it, or it may flatter them or surprise them, but they may sometimes still reject it.

- Today I was solely responsible for an entire cubicle. I couldn't believe that the Sister would do that to me. In the end, however, I managed perfectly.
  P1.2 w9codat.doc 729-732

- Today has really been a good day. I actually enjoy working alone. I was assigned with another nurse to look after the two liver patients in the single wards and that also was good because it gives me a sense of responsibility and a desire to do their nursing care to my best.
  P1.5 W5 codat.doc

In this assigned situation, the responsibility causes them to puzzle out and act well and thus it often brings distinct satisfaction

- In high care I at least feel more "together" - I know what needs to be done - to whom and when. By the end of the day I feel satisfied though. I have left nothing unfinished and the children are comfortable and happy (to a degree)!! P1.1 w9codat.doc 674-680
The converse is, however is also true. Students may feel overwhelmed or even fearful if they have been assigned responsibility that they feel unable to manage well:

In the case of the little baby, I think that a great deal of the fear I was feeling was because I have not worked with a child who is in an unstable condition before. Just all this responsibility can feel overwhelming sometimes.

Another aspect of the context is the student’s resources at the time of the encounter and the recognition of her responsibility.

I was feeling unwell emotionally and physically. It was hard for me to cope with the demands of crying babies with dirty nappies, hungry tummies and lonely hearts.

4.1.3. Do they assume responsibility or not, and what affects their doing so?

This third question raises the issue of student resources. What a student experiences in a ward setting may sap her resources to such an extent that she chooses not to assume the responsibility, even if she feels that it is hers:

I was overwhelmed with mixed feelings of anger and despair at what I had just seen. ...I just sat there and held the baby close to me, perhaps to comfort myself.

A student is more likely to assume responsibility she herself has recognised as belonging to her, rather than responsibility which has been assigned to her. This may be why it is an important causal condition triggering the way students work out or puzzle out their relationships with children and their parents.

I orientated the mother in the ward. I earned her trust at the time of initial crisis. I was responsible to teach the mother about intravenous line observations and care... and I explained their importance to her. I really felt sorry for this mother. I had so much empathy and (com-)passion for the child. I was also anxious since I did not know what was gonna happen to the child. I did not know what to do or to say much, but I made myself available to her.

This student spoke the mother’s language and happened to be there when her very ill child was admitted. Her sense of responsibility clearly caused her to remain alongside this woman even after the crisis situation. An added sense of responsibility came with the student’s understanding of the situation. The fact that she took on a role of interpreter and protector, was as a result of her sense of responsibility. This student displays dutiful safeguarding (2) see p.167 of this mother and child (An action strategy of puzzling out connection – more fully described later in this chapter in the section called Actions).
The responsibility she initially assumed in the relationship caused her to draw the conclusion that both the mother and child needed to be protected. This is not an uncommon experience for students in the sample.

Another way in which students assume responsibility is by doing something to “make it better”. Of course, knowing what or how to do something requires further puzzling out.

Student: But if that child cries.... It's got so many tubes and things going around him. "Am I going to injure it? Am I going to do something worse to the condition?"

And it's always: I've got to take back and think: what am I doing for the child?

Researcher: And you've got to work out how to care for him in that setting.

Student: Ja* (yes),... Is my loving hurting him more than what it is helping him.

The vigilance described earlier is often evident, as a student is doing something and students describe concentrating on this “doing” as they work it out:

Learning with sick children was a challenge for me because I notice when you do anything with them – like medication - with everything you must be so precise. I'm so scared. I don't think I'm that particular when I am nursing an adult. I shouldn't say that. Like with medication I don't want to give him more than I'm supposed to give him. You know because it can be harmful... You must be so particular with them because their whole life is in your hands.

The responsibility is often assumed as a triumph:

I enjoyed the feeling of responsibility and it was of course far more manageable having one child than a whole ward full. By the end of the day I felt quite attached to the girl simply because of the intensity of the time we had spent together.

Fourthly, a question students often ask is: Who should have the responsibility—the more senior nurses or the mother?

I am sure that they know that we are not their mothers. That limits us to an extent because we can only do so much and we cannot be there all the time. But I'm glad because I don't want to be with them all the time.

What I didn't understand is the mother who told me that the nappy was wet. I gave her a nappy and told her to change the child's nappy. She didn't seem to like that, but the child was hers.
It is striking that this is something which students spend much time puzzling out. Their conclusions are the clearest indicators of how they will choose to relate to a child and his parents. These conclusions are therefore causal in the actions and interaction strategies the student may choose. (These are merely mentioned here and fully described in the section Actions).

Either the student's conclusion is that the responsibility is not hers and she will not carry it, which leads to playful connecting (1) with the child. Having drawn this conclusion, she quickly hands the responsibility back to whomever will take it. Alternatively, the student may take on all the responsibility she identifies, which results in dutiful safeguarding (2) page 165 in which the student is reluctant to share her responsibility. Finally, the student may share responsibility by readily passing responsibility to the next willing and able person: this could be the mother or another able and present person. This causes the student to act in relay with the mother (3):

(1) I enjoy high care - Tracy is still there and it's nice being able to continue to care for her. Most of the time though, I find her parents are doing more of the caring and I'm assisting.

(2) The older ones often cry and they get upset for reasons that you can't always find. Or you can't always solve. "I want my mummy." But I mean, I can't be mummy. I can pick you up and hold you, but the child I find often cries for half an hour anyway, and yells just as hard when you put him down again. I can't be mummy, no. I can be there but I'm not mummy. I mean I don't look the same; I don't sound the same.

Responsibility is thus a condition that causes the student to puzzle out her action and interaction with the child and influences how she then relates.
4.2. Knowing

The second causal condition of puzzling out connection, which has emerged from analysis, is that of knowing. This could be information the student has acquired as knowledge about a child’s situation. Whether this is related to the child’s behaviour or illness, the student perceives it as information which either she has or does not have, and it causes her to work out what to do, or sometimes not to do anything. This aspect of “doing something” is related to knowing what to do and is therefore included in this condition of knowing.

As in the discussion about responsibility, there are some questions which will guide our understanding of knowing as it has emerged from the data.

- What elicits recognition of knowing or not knowing?
- How do students feel about knowing or not knowing?
- How do they respond to this recognition?

4.2.1. What elicits recognition of knowing or not knowing?

The first and most obvious answer to this question is that the student wants to do something and finds that she does not know how to do it. Alternatively, she could also be expected to do something, and not have sufficient information or knowledge. These are the two most common situations that elicit a recognition of not knowing for the student.

One writes:

I was worried that I would be somehow incompetent or inefficient due to my inexperience and this could somehow put the children in danger or hurt them eg. dropping a baby or something. I feel completely unprepared for this type of hospital setting! I just want to go back to my previous ward!... You always feel comfortable with what you know.  

Another records:

There is another child who was there when I started working in medical ward and she is still there. The diarrhoea becomes better and after two days it recurs. The child is three months old. I don’t know why he is not recovering completely.

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Students often perceive that ‘all there is to know’ will somehow make doing things with or for the child easier. The aspect of “finding the rules” discussed in relation to the intervening conditions of others present is one which students tend to rely on. Just like any game has rules, they expect this one also to have guiding principles, information and procedures. It seems that finding the “right way to do it” makes it easier and may result in less puzzling out. This is something students obviously find frustrating about trying to relate to children, especially initially, as they ask, “How do you do it?” They would rather not hear, “It all depends on the child”, or “It depends on how old the child is”. Of course there is some safety in knowing as it allows some predictability about what to do.

I went to Kay-Lynne to tell her that her daddy had phoned to wish her good night and she burst into tears. I felt an overwhelming feeling of guilt at having inflicted this “bad news” on this little girl.... I am still unsure about what I should have done...

As students begin in clinical settings with children, they often feel as if they need a whole new knowledge base before starting.

I’m scared that I won’t be a good enough nurse because my command of necessary knowledge is insufficient. I would rather be a child’s playmate than nurse.

It seems that it is only after starting that they realise that their knowing is broader than they anticipated. It is this realisation that is more likely to elicit what they do not know than what they do know and understand. The intervening conditions of remembering and others present contribute to this causal condition of knowing. Sometimes someone else will elicit the student’s knowledge by causing it to be triggered and remembered.

The knowledge students often do not recognise is that which they bring from their own experience, especially that of being a child or with children before formally starting this course component. The knowledge of another language would be an example of this:

The staff was not creative enough to convince him eat, simple because they could not understand what he was saying. When he shook his head to them it meant “enough” and the food would be taken to the kitchen. When trying to feed him I used to convince him that he is hungry because he has not eaten anything for the day. I also used to tell him in order to go home and see his family he must eat first; Since he was always in pain, I used to tell him that it is because he is hungry.
This student’s knowledge of Xhosa gave her an advantage over the rest of the staff, which resulted in a particular relationship with the child. The student’s knowledge of the child’s language gave the student access to him, and persuasion concerning his care that nurses with other knowledge were unable to offer.

Another example of knowledge gained earlier, is that gained by students, from their mothers who worked in professions dealing with children.

© The student sat with a little one considering the rest of the playground. When I went up to her she said her mother has a playgroup and so she is quite used to children. Especially of the age-group 4 to 6. She said that she was watching how the others, (students) struggled to keep them within limits. She said she was noticing how the children tired them, and they allowed them to climb on top of them and play with their hair. And she felt that one learned how to not allow that, or to set boundaries more clearly by example... by watching as she’d watched her mother.  

4.2.2. How do students feel about knowing or not knowing?

Student feelings about not knowing, range from feeling pressurised to feeling frustrated. Their level of discomfort can be instrumental in their responses in a given situation. The pressure that students feel is often related to the expectations of others.

Peer expectations are the first of these. If there are students who have had specific previous experience and the student group knows this, it may result in pressure from the group “to know”. The student group may then legitimise the member’s previous experience or refuse to accept it. This is unpredictable and it varies from one group to the next. On occasion, having worked in a children’s ward previously may be acceptable prior knowing, but in another group the mention of this is not welcomed. This is probably related to the group dynamics within different groups. Occasions of knowing which have been favourably received have been au pair work abroad and previous work at a local day care centre.

Pressure is also experienced by students in ward settings where staff may expect them to know more than they do. This is related to the fact that they are third year students and that the insignia they carry on their uniform makes this clear to other staff. Yet, unlike the other groups of students who pass through the wards, this is their first exposure to nursing children.
An added pressure is that they belong to a smaller group of students who are registered in a degree programme and are compared with the larger group of student nurses who are completing diploma programmes. This distinction is an interesting one, often recognised but seldom explored. Nevertheless, it constitutes a divide which is evident wherever it is found in South African hospitals, a divide as old as the ‘town and gown’ conflicts described in the university communities of Oxford and Cambridge (UK) in the early 1200’s: “[P]rivileges of University caused resentment and ill will among townsfolk and occasionally spilled over into actual violence” (Cambridge Official Guide, 1994:9).

Pressure from ward staff on the students to know, and the resultant competition in these settings, is often experienced as ‘one-upmanship’ by students.

There are some things about the staff I don’t enjoy....It is not the entire staff I don’t enjoy working with, it is only one or two people who are always trying to let you know that they know better than you and that they have more experience. It is almost as if they enjoy having someone around who they can order around and belittle. I sincerely hope that one day when I become a sister, I won’t be like that.  

There are sisters or professional nurses who are seen by students as knowing.

We have a very good sister in charge. She answers questions thoroughly and uses the proper terms so it doesn’t sound as though she’s talking down to us.

Professional nurses’ knowledge and actions are also eagerly watched and monitored: Sometimes students compare these with their own knowledge.

Nazlie started smiling. One of the sisters was talking to him and he seemed to enjoy that. I liked what she did. I just feel very silly when I try to speak to babies in that language. It doesn’t come "naturally" to me.

The presence of these able registered nurses is certainly an intervening condition for students as they seek guidance and take cues from registered nurses. There are mostly three but sometimes two or only one registered nurse on a shift and students do not often work closely with these nurses. The staff to whom they refer are often not registered nurses but rather auxiliary or enrolled nurses, with either one or two years’ training but often many years of experience with nursing children.
4.2.3. How do they respond to their recognition of knowing or not knowing?

If the student does know, whether in terms of information or ability, she often connects more easily with a particular mother or child. This could be because she speaks their language or has a family member of the same age. Familiarity or recognition does lead to making links and this is an important part of this causal condition to puzzling out connection in the situation.

There are also areas of knowing which students do not initially realise they need or lack. These areas often include the knowledge and experience of parents.

From that long wait I am now able to understand what it must be like for mothers who spend hours at day hospitals and clinics waiting for their children to be seen... We felt so helpless because we didn't know the hospital and because we weren't sure when the bus would come to fetch us.

Students' experience of parents is complex and is fully discussed in the section discussing action/interaction strategies. As it relates to students' knowing, however, it is significant to note that students often only recognise parents' skills or knowledge when a situation elicits their empathy.

In my mind I was trying to find a reason for this child's behaviour. The only conclusion that I could come to was that the child had not had one constant caregiver and had therefore been unable to form a trusting relationship with anyone. In this conclusion I was making huge assumptions about the child's mother and social background and I was to be proven wrong. Nosi's mother arrived during the morning and spent the whole day with the child. It took her an hour to get the courage to leave her [daughter]

As students' confidence in their own knowing increases, they are willing to test this growing competence.

In the evening... we had to put the children to bed and they were crying. The nurses told us that it is because we played with them too much that they won't sleep and that we should feel guilty because there are only two night staff to deal with the crying children. We ignored the comment.

This awareness of their own knowing results in a confidence to trust their thinking about what to do or around the information they require and this causes different actions. 'Knowing' therefore causes them to do and respond as they recognise what they do or do not know.
4.2.4. How then is *knowing* a causal condition to puzzling out connection?

A quote used earlier indicates how a student puzzles out her actions after a clear recognition of her not knowing and doing the 'wrong thing'.

> I went to Kay-Lynne to tell her that her daddy had phoned to wish her goodnight and she burst into tears. I felt an overwhelming feeling of guilt at having inflicted this "bad news" on this little girl... I am still unsure about what I should have done but perhaps at this age the child is still learning to trust that their parent won't abandon them and cannot conceive why they can't be sent home.  

The student puzzles out the reason for the child's reaction and this influences how she will act the next time she encounters a similar situation. This is a clear example of puzzling out connection. This recognition of not knowing is the result of a student acting by making a *playful connection*. It was preceded by a description of how much the student enjoyed interacting with this child, her first experience of nursing a child who was verbal.

> I enjoyed having "conversations" with her and was given a glimpse into the social world of a two year old!  

In this example, the student had engaged with the child as a peer or playmate and when she received the phone call from the child’s father, brought the child information that she herself would have wanted to hear. However, when the child’s response was not what she expected, or how she may have reacted herself, the student had to return to the puzzle of how to connect in this circumstance. The remainder of her reflection and report indicate how she then moves into another mode of relating: that of *dutiful safeguarding*:

> I realised that by telling her, the feeling of separation would only have been strengthened and she would probably have felt more lonely and separated from her parents. I felt terrible having to leave at 19h00 with Kay-Lynne still so upset and I feared for how she would be treated by the night staff in this vulnerable state.  

There is an aspect of *knowing* which is clearly a causative factor in students puzzling out connection with a child and often also with a parent. There is particular 'knowing' that is causal in the students' connecting especially in the context of a terminally ill child. This connection is the most complex for students to consider. It is a connection they would rather avoid and it seems to be complicated by another kind of knowing: knowing what it is that the doctor knows.
This may be the prognosis or the stage of the disease as perceived by those who are regulating and prescribing intervention. A student does not usually want the information because she wants to tell the parent, but rather because the knowledge can guide her interaction. This excerpt is from some participant observation:

© There was an exasperated sense about the student. Obviously, this was a child with many problems and she was unable to identify a medical diagnosis. She was a four and a half year-old with epilepsy, who had had an appendectomy, because they felt that was the cause of the pyrexia. They found it wasn't, then the wound had gone septic and opened up. The child had been unresponsive for almost two weeks. She was obviously developmentally delayed, had cysts on both her kidneys, pus but no organisms, and generally has an uncertain medical diagnosis. So she kept saying: “I wish they could just find it, so that we can know.” “Would a medical diagnosis help?”... She said: “Well then at least if we knew what was wrong, we could do something about it.” I said: “And then she’d get better?” She said: “Yes and then she could go home.” I said: “So what you are saying is if we knew - there would be hope?” “Yes, I suppose that’s what I’m saying,” she said, “just a little bit.”

The students trust that doctors have this knowledge but are not always willing to verbalise it.

If I know that a child has TB for example, then I know that they (the doctors) plan for the child to go home - I know that the mother or somebody needs to take the child for medications....Then I can go to parents and I can say: This I know. This is what I can predict for the next six months. It is what you’re going to have to try, and fit into your lifestyle that this child needs to complete TB medication. Whereas, if I wasn’t so sure about the diagnosis, and I was trying to plan this child’s care, I couldn’t do it effectively. And so almost in this situation with this child who has AIDS I need to have some idea as to whether they really don’t think this child is going to survive at all.

It is evident that knowing gives the student something to ‘go on’, it causes her to work out how ‘to be’ or respond. Even though I had asked the previous student about hope, this theme did not emerge significantly in the initial analysis. It was only after focused data selection and analysis that hope re-emerged in this condition of knowing. Hope was then recognised as it appears early in the phase of anticipation. It is evidenced in what students expect children to have or to be: the promise of something better, potential for wellness and the promise of so much as they are growing. The knowledge that the children they encounter often have less hope is clearly a causal condition in how they will engage.
Researcher: What I'm wondering is whether anybody knows... What's the likelihood of their knowing?
Student: I think they will have some idea as to whether the child is going to actually survive or not.
Researcher: Possibly.
Student: But they won't have any idea about the level of disability.
Researcher: They probably don't even have an idea of the prognosis. When you say, if they could say: if only you could give ... hope for this child, what does hope mean?
Student: No. The way I meant it was that they're almost giving the mother hope by visiting every day and trying new things. "We're going to try this and we're going to try that." Then that is conveying hope to her, because there is still more we can do.

As we conclude this discussion of the two conditions that cause students to puzzle out connection, responsibility and knowing, it is important to clarify when these causative conditions are seen in the process of student learning.

These conditions are evident from the earliest stages of anticipation to the phase of engaging. In the initial phases, of anticipation and encounter, students anticipate and speak of their sense of responsibility as they consider their concerns about a child's safety and well-being. In these early phases students ascertain their knowledge and judge how well they will manage with what they perceive as very little knowledge. Of course, there are those students who anticipate enjoying the experience because they enjoy children. This familiarity with children brings with it the sense of having the required knowledge for the task and knowing what to do with children. An additional aspect, that of hope, is seen in the anticipation phase. Students anticipate that with children things should go well and experiencing this hope or dreading its lack, is seen as an early causative condition in the process of engaging with children.

The role of both responsibility and knowing are clearly evident as causative in the phase of undertaking connection. The descriptions in the discussion thus far indicate how students puzzle out a connection with particular children as they consider and assume the responsibility and work out what they know in various settings. The different responses are playful connecting, dutiful safeguarding and acting in relay with the mother. It is clear that the possibility of not engaging but choosing only to 'get the job done' can also be the result of these two causal conditions. This will be more fully described in the following section as distant doing.
Section 5: Action and interaction strategies

This section brings us to the purpose of the students' puzzling in this process of learning to nurse children: contact with a child or connection. What the students do as they puzzle out connection. The descriptions are thus of what the student does as she connects in this next phase of the process:

anticipation → encounter → connection by

playful connecting OR
dutiful safeguarding OR
in relay with child's mother OR
distant doing

The four action or interaction strategies that emerged from analysis have been introduced to the reader and will be fully described here. They are: playful connecting, dutiful safeguarding, (acting) in relay with the child's mother and distant doing. A full picture of the conditions that influence each action is drawn in the conclusion of each section.

What students do as they puzzle out connection with children

The four emerging modes or strategies of interacting in this study were not found to occur sequentially as a student learns. Sometimes one type of action seemed to be the pattern of individual students. Other students used different actions with different children as they were influenced by different conditions. The consequences of different actions were also seen to contribute to actions in subsequent situations with other children and might have led to a different strategy on those occasions. These actions are therefore presented here with the understanding that they are not merely sequential in each student's learning process. At this stage, it is not suggested that the first is any less appropriate or the last any more sophisticated. The actions are presented here as the strategies students use in various settings with children. In presenting these as students' strategies, I remind myself that my purpose was to understand their learning process more clearly and to present what happened as they learned with integrity and without judgement. I will consider the implications for educators and student learning in the discussion in the final chapter of this thesis.
Puzzling out connection through **playful connecting**

- Student moves into child's 'team' and pays less attention to getting done
- Remembering
  - Student remembers experience of being a child
- Anticipation
  - Student likes children and has some or limited resources
  - Child is not very ill and mother is not present. Student can communicate with child
  - Others Present
    - Student sees others present as responsible
- Encounter
- Connection
  - Playful connecting
  - Dutiful safeguarding
  - In relay with mother
  - Distant doing

**Responsibility & Knowing**

- Student is reluctant to assume responsibility for childcare AND has incomplete knowledge and experience base

*Fig. 5.4*
5.1. Playful connection

The key feature of this kind of engaging is that the student relates to the child by identifying with the child. They connect like fellow players in the game, either as teammates or as opponents. The student relates to the child’s situation and may find it familiar. This means that she can draw on her resources of familiarity in understanding the child and the situation. Consequently, the student’s expectation of the child in this type of interaction is similar to what she would expect of herself or a peer. The expectation is often not related to the child’s developmental stage or ability. Figure 5.4 illustrates this mode of connecting.

In the playful nature of this interaction the situation may arise that the child acts in an unexpected manner and the student will then express her disappointment or even anger at being let down by the child. This is sometimes seen when a student has prepared to demonstrate her skill to a clinical instructor. She has a playful connection with a particular child and prepares to demonstrate the skill with this child, but some part of the process is unpredictably different as the child falls asleep or is not hungry and refuses the feed. The student then has the experience of being let down and not ‘winning’. Sometimes however the plan works out and the team effort is rewarded. The following data exemplifies the latter scenario. The student’s interaction with the child is indicative of team play:

© The student had chosen a small five-year-old to practise and show me how she would restrain a little one. She had obviously negotiated with the child that she was going to play with him for a time, while she (student) showed me some things. She had let the child play with her tools, the plaster and the bandage, as well as shown him how he was going to be wrapped up. The interaction was quite sweet. At one stage the child interrupted and the student said: “I want to speak to this auntie now, but I promise you we will play with the balloon; we really will.” And the child was quiet.... Then as we were finishing the child said he wanted to go to the loo. The student immediately said: “All right let’s go.” Picked him off the bed, told him to put his shoes on, and then the two of them left. What was interesting was how the student let him: do it himself. Whereas I’m sure someone else would have picked him up and carried him - probably put his shoes on for him.

This encounter demonstrates a common student strategy that in this instance also got the task done.
Unexpected conditions would have changed the outcome for the student who gauged that the interaction had gone well. The context was a small but well-verbal and compliant child teamed with a student fluent in the same language, with resources from previous experience with pre-schoolers. Remembering that playful negotiation usually works and settled in her recognition of a safe relationship and her knowledge of the skill, this student had utilised playful connecting as she puzzled and planned the interaction. She expected the child to manage his own shoes and he did.

Another aspect of this type of engaging is that the student identifies with the child more than with the staff team. In this example, the student speaks the same language as the child and after she has enticed him to verbalise she shows him how she can understand and empathise and is really on his team, not on their team.

When I first approached, him he was a very quiet and shy child. I tried very hard to manipulate him to speak.... I then got a chance. When I took him to X-rays, he started answering what I was asking him, things about his family, and his main problem was missing his parents and sisters and wanting to go home because in hospital [it] is not nice [and] they make him sore. That was then my chance, because I tried by all means to make him understand.... Whenever they were doing anything to him I was always with him helping whoever was doing the thing.... I use[d] to keep him occupied by songs and tell him stories, like when I was his age I was once in hospital, I use[d] to be strong, not cry or fight with the nurses when they were doing something, so I would suggest that he do the same thing. And you would see that even if he was beginning to cry, he will start telling more stories and more songs making himself strong and this use[d] to be funny to the staff. They would laugh at us and in the mean time we were trying [a] means of coping with life at that time.

In this example, we see the expectation of the student, related to the child's behaviour. The strategy she uses works for both her and this child. The way she makes sure that he realises she is on his team also allows her to relinquish some of the responsibility for hurting him. She can empathise freely with him, express her anger and as his team member, she allows herself to feel his emotions. The interaction conveys the impression that they are mates and that they understand one another.

In this type of engaging the student sometimes expects behaviour beyond the child's developmental ability. Even though students are often able to recognise and even recite the theory related to childhood development, in working out how to respond,
this student expected a child to display understanding beyond his developmental age. She recognises the child's behaviour and in puzzling out her strategy displays the peer or mate action in her response to the child:

I spent the morning with the 2-3 year old group.... One child seemed to be regressing. She sucked her fingers a lot, wanted to be picked up and clung to me which she didn't do the last time I was there. When she sucked her thumb she placed her free hand on my breast. I did not mind because she wasn't squeezing it or making me feel invaded in any way. I just thought it was a bit "funny" that she was doing that at all. Anyway, I asked her to touch her own body if she wanted to do that.

Another facet of this type of interaction is that the student expects the child to enjoy any interaction that she would enjoy. In the same way that adults often expect children to enjoy being tickled, a student in this mode of relating often finds it difficult to imagine that the child may not like or want this style of interaction:

When I pick a little baby up then I just squash it and squeeze it! I just hold it and hold it. It is actually delighted. I think what I was trying to say is that I've been given the opportunity to love a lot of children at the same time and to see how I would respond to loving and caring for a child. Here I'm given this opportunity and I see what I can do with it.

The focus of this interaction is clearly the student and what she would like and how she would respond to the interaction with babies. This occurrence of being central to the motivation for action or interaction is not uncommon in students. A student describes her relief that she could spend uninterrupted time with a child after investing some time to draw the shy little one out a while earlier:

Because he was on strict bed rest I found that I could spend more time with Tess and not have any unwanted interruptions from the other children in the ward.

This competition with other children for the undivided attention of a child is also seen in interactions with mothers of children with whom the student would like to spend time alone. If they do have a favourite child and the mother is present they sometimes feel resentful of the mother's position:

And also sometimes I find that when you have got a favourite baby, and then the parents are there, you almost feel a bit sort of sad that the parents are there. I know for the baby it's the best thing, but for you, you can't help but feeling: I would like to be working with that child now.
Puzzling out connection through **dutiful safeguarding**

- Playful connecting
- **Dutiful safeguarding**
- In relay with mother
- Distant doing

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Student is conscious of getting done and affirmed by her significance to child

**Remembering**

Student remembers experience of being parented

Student may or may not like children, but recognises some resources

Child is often ill and mother often absent. Child may not talk, but student recognises response

Student sees others present as not willing or able to take responsibility

**Anticipation**

**Others Present**

**Encounter**

**Connection**

**Responsibility & Knowing**

Student assumes responsibility for care; whether confident in knowing or not

**Fig. 5.5**
Feelings like this could obviously influence student actions as is illustrated in the following example. This student had been trying to connect with a baby for some time. She then worked out that his current physical condition made this an unrealistic goal. Further knowledge became the causal condition to her puzzling out a different strategy of connection but this had additional and unanticipated consequences:

I moved to attempting to promote his sleep for comfort rather than tiring him for a smile. One day I managed to get to his bedside before his mom did. I took the opportunity to give him a bath. Immediately after this he fell sound asleep. Having made sure he was neither exposed unnecessarily nor exhausted by the bath, I took the peaceful sleep as a sign that he enjoyed the bath. His mother later came in with such eagerness to wash her baby. She felt disappointed when I informed her that he had already washed. Guilt led me to the decision never to wash him again until his mother arrived to give me permission to go ahead or bathing him herself.

This is an example of the consequence of an action with a child causing the student to reflect and her decision for subsequent action could easily be described as being in relay with the child’s mother. It illustrates how the consequences of one mode of engaging contribute to the influencing, contextual and causal conditions of a subsequent interaction strategy. It shows that the consequences of the student’s puzzling out action now contribute to each of these conditions:

<table>
<thead>
<tr>
<th>Contextual Conditions</th>
<th>Student</th>
<th>Added Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td></td>
<td>Really acknowledged mother’s presence especially as communicator with the child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervening Conditions</th>
<th>Remembering</th>
<th>This experience becomes a measure and clarifies the “rules” about mothers’ roles further</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others Present</td>
<td></td>
<td>Recognises the mother as support in care and therefore action</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Causal Conditions</th>
<th>Responsibility</th>
<th>She may hand it back to the mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing</td>
<td></td>
<td>Has recognised additional experience and information</td>
</tr>
</tbody>
</table>

In conclusion, it seems that this mode of engaging, playful connecting, is most likely to be adopted in situations where the student likes children and has some or limited resources. It is also seen in situations where the student encounters a child who is not very ill and whose mother is not present all the time, a child with whom the student can communicate in some way. Intervening conditions would include the student’s remembering her experience of being a child and her interpretation of those present as responsible, leaving her with less of a burden of care. The conditions, which would most likely cause her to act in this mode of playful connecting, would be her reluctance to assume responsibility and an incomplete knowledge and experience base. [See Fig 5.4]
5.2 Dutiful safeguarding

Dutiful safeguarding is the mode of engaging characterised by a conscientious protection of the child. (Figure 5.5 illustrates this mode of connecting.) As the student connects with the child as his guardian, she is more likely to be the coach or the referee in this ‘game’. The child is seen as vulnerable and unable to fend for himself and therefore requires vigilant custody. The student does not usually expect the child to participate and is more likely to prevent participation as she keeps the child on sure ground or where she considers him safe. As the strategy does not welcome participation a mother is not usually present with the child unless she, too, is seen as vulnerable and in need of security. An adolescent mother could fit this description and be engaged in this way.

The student nurse will often resort to dutiful safeguarding in the absence of a child’s mother as she assumes the responsibility of acting in the mother’s stead. If the student perceives that the child is or has been neglected, her sense of responsibility increases. This is only reinforced as her commitment to the child grows, especially if she recognises her anger or hopelessness. The responsibility often increases the student’s protective defence of the child and may also include shielding the child from other team members. She is likely to temper her actions with the justification that the others do not have enough time or resources to give the child as much as she can. Her commitment to the child’s security therefore results in her defending him.

As the child must be kept safe, the student requires his obedience. She is also likely to protect him by doing things for the child, so that he does not need to exert himself or be unduly challenged. Once again, the unexpected in this setting really disrupts the student’s strategy. A child who will not comply or behave as expected is difficult to understand. In this regard, however, the data in this study contains many more descriptions of children who comply than those who do not. Students are, of course, often describing the children with whom they have puzzled out a connection and been successful. The ones who are described as “irritating” are often those who were not compliant or “well behaved”. These descriptions are not usually of children with whom they have engaged, unless the description is to record a triumph of a strategy that worked with a previously “irritating” child.
Students ascribe compliance to children who have “learned the rules” and sometimes they express their difficulty with this; most often, however, when they are the observer of another’s “dutiful safeguarding”.

The student who is using this mode of connecting with children is often quite sure of her own resources, she definitely knows the ‘rules’ and she may feel confident that she knows and understands what is required in the situation. She may like children or not, but she will rely on her experience, usually of being parented, in dictating how to respond. She is therefore relying not on her own experience of being a child, as in the case of playful connecting, but rather on her experience of being cared for. The student may also want to act differently from the way her own parents acted, thus offering the child something she did not experience.

The following is a description of students’ interaction with a specific child that demonstrates various actions and how they came about. Further features of puzzling out connection with a child in this mode of interacting will then be discussed with reference to shorter data portions.

**Student 1:** We’ve got this little boy (7yrs) in our ward and he has been in high-care since I’ve been there, and now he is on a side-ward. But from the first day in that ward, the only words he says is he wants his mum and dad. And that was for the first sort of week-and-a-half. And I haven’t seen them in the ward once. They haven’t come to visit him once. They haven’t come to visit him once. And now he’s stopped even saying that, and he’s just kept quiet. And with parents like that you just can’t help feeling: how can they be so cruel?

Researcher: How do you feel about that mum?

Student 1: I won’t say I blame her; it’s not that you have a negative sort of feeling against that mum. It’s almost... I suppose you could maybe....

Student 2: I feel anger. I feel very angry about it. I mean surely they could make the effort just to come once a week, so he is not completely cut off, feeling abandoned almost, neglected.

Student 1: I wanted to phone Cliff’s parents but there wasn’t a contact number. And the only contact number was an aunt, so then I asked the sister to phone the aunt. And then the aunt actually came to visit about three days later. So at least he had some contact. But it still wasn’t the mother. He didn’t even talk to the aunt, which was still upsetting to see.

Student 2: So he was like in a complete depression.

Researcher: So what do you do with a child like Cliff?

Student 1: I think you almost try and replace the parent figure that they don’t have with what my expectations are of the parent. The nurturing, the loving, the TLC. The being there, the stimulating. Trying to do what the parents should be doing.
Student 2: I think in nursing them you almost find that you want to actually give those children a little bit more than what you're giving some of the others whose mums are there constantly for them. So you are always there checking up. Do you have enough of this? Or is there anything I can do for you? Or let me just spend some time here.

Researcher: What about this little boy... Cliff?
Student 1: I've got a bit of a soft spot for him. So from the beginning I've been trying to get him to smile and everything. And I started off slowly, just throwing the ball to him. And he would try as hard as possible not to crack a smile. And then he would eventually started smiling. And then I got him out of bed, and I've been walking with him every day that I've been there - just to get him stronger. And now, this morning when I haven't been there for a while, it was such a nice feeling because I walked into the nurses' station and as soon as he saw me he like started beaming from ear to ear. Ja, that was a nice feeling.

This conversation involving two students indicates the shared nature of this experience for them. The first reference to the child is that his parents are not with him. The students are sometimes reticent to express their reservations or feelings about a child's parents, but peer encouragement often elicits the feelings of anger about apparent parental neglect. The child was also typically an ill child who required care in the high care unit. The students then conclude that his parents are not going to be around so they take on a parenting role, enticing him to smile - connect with him and doing things for him to enable him to get stronger. In this setting, the one student, in trying to remedy the situation, found the child's aunt rather than the parents visiting. The outcome was "still upsetting to see". The aunt failed to engage the child in conversation and this only reinforced the student's desire to do this. The student is also reassured in her efforts by the child's reinforcement in recognising her. The outcome of her interaction with him becomes the measure of successful outcome, rather than the success of seeing him interact with his parents, and reinforces her role as guardian.

A feature of *dutiful safeguarding* is that students expect children to learn or obey when instructed.

I spent some time with a three year old boy. I read a magazine with him.... I questioned him on colours and other objects such as cars, rings, pretty women, shapes etc. He didn't always know his colours, but then I corrected him and pointed out objects in the playroom that were of the same colour. I then asked him a few minutes later about the colour, but he didn't always remember. I also allowed him to help me feed a baby.
Students often use methods of communication like instruction or testing knowledge or performance in these interactions with children. The emphasis is on following instructions rather than participating in the activity or interaction. This further indicates their sense of responsibility for the child not only to care and to protect but also to assist the child to learn. In essence they feel responsible for any need they may recognise while interacting with the child.

An example of how a student assumes responsibility occurs in the following description of a student puzzling out her connection and clearly dutiful safeguarding a much younger child:

Nathan (5 months old) liked to be held in my arms and looked at me with big eyes. He looked as if he was to say, “Sure, can you believe it somebody actually picks me up and talks to me...”. He felt as light as a feather and continued looking at me in total amazement. The main reason why I had picked up Nathan was his cry and discomfort. I just felt so sorry for this little helpless being, which seemed to benefit so much from just being held in my arms. I changed his nappy and gave him his bottle and that is how the story begins!

The student describes nursing this little boy with Trisomy 13*, for three consecutive days while he was recovering from dysentery* while also in cardiac failure*. Her detailed account indicates her meticulous observation of how he dislikes being bathed:

He did not like getting undressed and ready for a bath. I think he gets cold quickly and bathing uses up a lot of his energy so that he actually becomes quite anxious. He showed me his feeling very clearly. Loudly protesting he aired his view like, “No, I really do not like that!” I tried to quickly bath and rub him so that Nathan would not get a cold easily. Nathan’s buttock still shows signs of a previous rash, which must have occurred on his last episode of diarrhoea.

Nathan is very tiny which is partly due to growth retardation but can also partly be due to lack of warmth and love given to him. Nathan is so much underweight that it is good that he is hospitalised because with his weight he needs to be monitored carefully. In order to have a proper constant weight gain Nathan needs more love and attention than just more food or stronger bottle-feeds. I never saw anybody popping in and holding him.

She knows from a letter to the cardiologist that his parents are not together and are unwilling to take him home before his cardiac lesion has been repaired. The student reports this as frank detail. She indicates that, “the hospital is the best place” even when there is “a lack of love offered to him”.

P4.6 narrative.doc
Nathan is such a lovely little boy and I really find it hard to distance myself from the whole problem. He observes everything that one does and he is very relaxed when being held. Nathan does not like to be “shut up” with his dummy. He always spits the dummy out. Unfortunately one cannot spend most of the day with one child only, otherwise he would have been the child of my choice to be close to. Recently (2-3 days ago) the staff inserted him a naso-gastric tube because it “took him too long to finish his bottle.” I wonder whether they know that they should use the same time for feeding with a naso-gastric tube as well. Since I met Nathan he has not been to the High Care Unit but apparently he had to be monitored there initially when he arrived.

The student describes her different care of the child, and implies that others “shut him up with a dummy” and do not have the patience his care requires. She puzzles her connection with the child and tries to quantify the relationship while she protects him with her care:

I do not know whether something like bonding between Nathan and me occurred but I definitely feel attracted to him as a caregiver. One of the reasons might be that he responds to my talking. He does not smile, which might be expecting a little bit too much and maybe he already is mistrusting everybody because there is nobody constantly with him. He does not have a single person who is permanently with him. He is basically alone and on his own. His prime caregiver is missing.

Even though she does not assume to be this primary caregiver she is aware that nobody else cares for him with such vigilance. While with me in the ward, she laughs with some discomfort, perhaps embarrassment, when the other staff call him “her baby”.

Another student is more verbal about her suspicions that a child is being neglected, this time by the staff. There is little evidence that students respond in different ways to their perceptions of neglect, be that by parents or staff. Even though it is obviously more difficult for the student to hide her feelings from the staff who are present, than from absent parents, some students become only more vigilant in their safeguarding:

I spent quite a lot of time today with a small baby who is dying of AIDS. The baby weighs 2.5kg and is 4 months old. She is covered in open sores and has oral candidiasis* all over her mouth. The nurses just seemed to ignore her all the time and she is always the last person to be fed - if she is fed at all. I have been giving her every feed but it is heartbreaking to see the pain and agony on her face as she tries to drink with open sores all over her mouth. Usually she vomits up most of her feed within five minutes of giving it to her as her failing body can no longer tolerate any fluids. Each bottle of 40 mls takes about 15 minutes for her to drink, so I always get comments that I am spending too much time with one child but no longer react to them. I know what my priorities are and I’m going to use my own initiative.
This student's determination and her reliance on her knowing, cause her to persist with the child at the risk of exclusion from the staff team.

The four-year-old child in the next description had been very ill for the previous three weeks and at times described as terminal with HIV-related pneumonia. She had been gradually recovering, much to the amazement of her attentive and meticulous student nurse. The child's mother had not been to see her in that time and the staff had often seemed to give up on her. In previous descriptions this student had described just sitting with her holding her hand:

It was comforting for me to know that this was at least something that I could do for her when the journey from life to death was out of my control. Her eyes looked at me longingly as if she was just surviving on love and attention and everything else has already gone.

Now three weeks later she was well enough to be placed into a bath rather than being sponged in her bed.

She absolutely loved it and took control of the whole situation. She took the cloth and started washing herself with so much determination and strong will it was wonderful to see. Despite all the tubes still attached to her for oxygen and fluid she was still a child with potential, despite being so ill she was capable to doing things for herself if given the opportunity. We washed her hair and let her play in the bath for a while. This bath time was the first instance when I had seen her actively try to take control of a situation and not be passively dependent. She had always just relented and let the nurses and doctors control everything but now I could see that she had the will and strength to start looking after herself.

It made me realise how easily we do everything for sick children as a "protective measure" because we see them as feeble and weak and therefore dependent on us to meet their every need. We rarely give sick children the opportunity to perform even the most basic self care needs. We are in fact stripping them of their identity, personhood and control and this should be seen as seriously as when we nurse an adult.

This is a clear recognition of the action and interaction strategies this student was using. Her puzzling out a connection with this child brings the recognition that a shift in action is possible, while also realising that it may even have been appropriate earlier. The consequence of daring to place this child in a bath, a different action from the protective one, is that she is able to regain her ability in the previously familiar environment of a tub full of water.
The result for the student is that she is adds to her own resources as she risks and the experience adds to her knowing which is likely to influence her next interaction in a different context. For example:

<table>
<thead>
<tr>
<th>Contextual conditions</th>
<th>student</th>
<th>Additional resource required in risking.</th>
</tr>
</thead>
<tbody>
<tr>
<td>child</td>
<td></td>
<td>She acknowledges decreased severity of the child's condition.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervening conditions</th>
<th>remembering</th>
<th>This experience offers one for comparison and redefines the “rules” about an ill child’s ability for self care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>others present</td>
<td></td>
<td>She recognises a peer as support in care and therefore action.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Causal conditions</th>
<th>responsibility</th>
<th>She may allow the child to share it.</th>
</tr>
</thead>
<tbody>
<tr>
<td>knowing</td>
<td></td>
<td>She has recognised additional experience and information.</td>
</tr>
</tbody>
</table>

**In conclusion**, it seems that dutiful safeguarding is most likely to happen in situations where the student, who may or may not like children, but recognises she has some resources, encounters a child who is very ill and whose mother is not present. The student may not be able to communicate with the child directly, but often recognises some response from the child. Intervening conditions would include the student remembering her experience of being cared for and her interpretation of those present. She often perceives those present as not willing or able to take responsibility for the child’s care, leaving her with this burden. The conditions which would most likely to cause her to act in this way would be a sense of duty to assume responsibility, which may or may not depend on her confidence in her own knowledge and experience base [See figure 5.5].
Puzzling out connection in relay with the mother

- Remembering
  - Student remembers experience as child and adult
- Anticipation
  - Student may or may not like children, but recognizes resources
- Encounter
  - Child's mother is present, and student recognizes her as his resource
- Others Present
  - Student sees others present as having information and expertise to share responsibility
- Connection
  - Student engages mother and begins to know child
  - Student may or may not like children, but recognizes resources
  - Child's mother is present, and student recognizes her as his resource
  - Student sees others present as having information and expertise to share responsibility
- Responsibility & Knowing
  - Student assumes responsibility intermittently. She understands the mother's role and knows when to help

- Playful connecting
- Dutiful safeguarding
- In relay with mother
- Distant doing

Fig. 5.6
5.3. In relay with the child’s mother

Engaging in relay with the child’s mother is characterised by receiving and relinquishing responsibility for the child with equal ease. (Figure 5.6 illustrates this mode of connecting.)

This action is different from partnership with the mother in that there is cooperation in the hand over but the burden is not jointly carried between the mother and the student thereafter. They do not assume co-operative ownership for the progress of the child. It is as if the student recognises the mother as an expert player arriving to join the game. She considers her carefully and then welcomes her as an asset to the team, but while the newcomer (mother) is playing, the student watches and cheers, fielding any balls which come in her direction only with the purpose of returning them to play.

This manner of puzzling out connection is most easily recognised by deductive analysis of the data. It is seen in how students describe mothers rather than in clear descriptions of what has been done. Once deduced, evidence thereof is much easier to find. Students often puzzle out the role of mothers as they encounter children. They try to work out what they do and are supposed to do. They compare them with their own mothers and grandmothers, and they often work out their own thoughts and feelings about being parents. At this time of their lives they may also resist being mothered and often they resist the connotations related to their mothering. These social and thought processes may well influence all their interactions with children, but the visible outcome of their reflections in terms of this strategy is that they are sometimes willing to run alongside another child’s mother for a while. As they receive and relinquish the baton, they puzzle out this dual relationship with mother and child.

Initially, they avoid mothers as they see them as knowing and having the authority of kinship with the child. “She knows the child,” they say, “after all she carried it for nine months.” As their confidence in their own ability grows, they venture closer and in this relay interaction, communication is related to sharing information.
The mother has the experience of the child to offer and the student has access to the information others have accumulated about the child and his condition:

At first, Dan (6 months old) never responded to anything I did or said. He would just lie there and give a feeble cry most of the time. I would tend to him most of the time when his mother was not around, i.e. feed him and change his nappy. Whenever I had extra time I would give "cuddle time". When the rest of the babies in the cubicle were sound asleep it would be Dan that was left crying, a cry that was barely audible. I would then sit by him, hold his hand and try to lull him to sleep. While doing this, I would often take his file and read. I just had to know more and more about him all the time. I used to go home, read about Rickets and always came back to tell his mother about the illness. Already knowing that Dan needed unconditional support, I soon realised his mother also needed unconditional support. My talks with her made me realise that life outside the hospital can be much tougher than you think.

This student has placed herself in a position of being with the baby when his mother is not around. There is no evidence in her journal or other communication that she received any response from the child. She says she is sure he is unaware of her and yet she persists and sees her work as supportive to the mother. In this engaging strategy, the student keeps the mother informed and supports her through their sharing of information. This is in contrast to the first two action strategies discussed in this section, where students describe avoiding mothers in case they expect them to have information. The information she receives from the mother enables her to understand and empathise with the mother-child couple. Another student describes her understanding of this dyad:

The two had come a long road together. This applies both figuratively and literally. My goal was just to ensure that their bonding is not disrupted by medical and nursing intervention. The together of child and mother are the story of my relationship with the child.

As students start to understand the role of the sick child's mother better, they recognise the regular presence the mother offers to the child.

I wanted to get know her and her mother better as well as giving them a chance to get to know a little about me. We got on well together and the mom is very helpful around the ward. She is a good mother to her own child and most of the older children whose mothers don't visit them on a regular basis.

Sometimes students want to be known too. So in an easy, comfortable relationship with an apparently coping mother, they find comfort and acceptance in disclosure.
As students explore the mother’s role they describe it as a special relationship, which carries responsibility by virtue of a mother having literally carried the child. It is a relationship that is about nurturing and loving. If asked to contrast that with a nurse’s role, students mention doing things like giving medication and information. They conclude that the nurse’s role, like the mother’s role, is doing and being with the child.

The conflict for them therefore arises when the mother is there and this means that they have to move out of the ‘being with’ or nurturing role with the child, as it rightfully belongs to the child’s mother. These students describe the nature of their puzzling out and call it ‘stepping on her toes’:

- Student 1: Well if I think of the patients whose mums are there, I find you don't sometimes enjoy that nursing as much because you can't get as involved - as [student 2] was saying. You're basically responsible for giving the medication, giving advice. Finding out how the baby is and everything. But you're not actually that involved in hands-on care. Do you know what I mean? Like that nurturing. The sort of non-medical side of things.
- Student 2: You don't have that bond as much.
- Student 3: Yes. I think it's not that nurse instinct, but it's that ... I don't know, I think each person must have an instinct to just care for someone. And it's almost as if you don't care completely. Not that you don't care, but that you don't totally give all of it when you know that the mother is there, because you don't want to override what she's already been giving her child.
- Student 2: You don't want to step on her toes.

As they move towards considering acting in relay with the child’s mother, they continually clarify their role or try to do the best thing. Students often experience extreme ambivalence in this. They want to perform what they understand as nursing ‘procedures’ and yet they also want to nurture and hold the child or baby. When they are able or allowed to do this they speak of “caring fully” or “with their whole being”.

Staff feedback and unspoken messages do not assist but rather add to the difficulty and confusion for these students in certain circumstances. Staff often remark about student interactions, mostly in terms of ‘spoiling’ children. Students pick up these messages in various ways. Some ward staff use non-verbal behaviour, or indirect messages like lingering around conversations to children or parents or tell students that there is “work” to be done. This reinforces the dichotomy between doing and being with.
It is as students puzzle out these relationships that they are more willing to engage the mothers. It seems that recognition and understanding of their role as nurse facilitates their ability to move into relay with the mother of a child they are nursing.

This student believed that a mother's relationship with her child "...is a relationship that only spending quality time can develop." She carried this perception with her into a situation where she was bathing a very ill and distraught sixteen month old:

Once she was in my arms after the bath she calmed down but if anyone came near us she got scared again.... In my mind I was trying to find a reason for this child's behaviour. The only conclusion that I could come to was that the child had not had one constant caregiver and had therefore been unable to form a trusting relationship with anyone. In this conclusion I was making huge assumptions about the child's mother and social background and I was to be proven wrong. Nosi's mother arrived during the morning and spent the whole day with the child. It took her an hour to find the courage to leave her as every time she tried to leave the child screamed and went hysterical.

Her preconceptions led her to assume that a frightened child meant some level of neglect of the child, but this situation proved different. Reflection and puzzling out the mother-child relationship assisted the student in moving into relay with this mother as she assisted the child in her absence. This mode of engaging by the student is often recognised by mothers and once a relationship is established with a student they will elicit their assistance or commission the student with the care of their child:

Whenever his mother wants to leave for a while, she will ask me to look after the child, because she knows that Siya is not afraid of me anymore.

Students certainly puzzle out parents' responses to their children. If they are trying to be in relay with the mother and want to come alongside her they may try to assist in getting the mother back as a player in the game.

But I know there are a few little children [whose] mothers only come when maybe the doctor wants to see them, or if they need to sign consent. So it doesn't matter that maybe they can't come in all the time, but it's almost as if they ... I don't know if they're cutting themselves off from the child. Maybe they can't handle the dilemma that the child is going through, or the health problem that they're in.
This clearly differs from the previous mode of engaging with the child when the student becomes angry at the parent’s absence. Now she is willing to be there for the children while she tries to understand the mother’s dilemma.

In the context of a relationship where sharing information and understanding is so important it follows that students find not being able to speak the mother’s language a frustrating hindrance:

John (a Xhosa-speaking student) had spoken to her but I still felt awkward because I so wanted to relate to the woman myself and I felt like a third party. The mother stayed in the ward for the rest of the day and when she left she gave me a big smile and said goodbye. That smile treated me so much and it was as if any barriers which we have between us had melted.

As might be expected, it is not only the ability to speak a mother’s language that affects the student’s ability to engage the mother in the game. The group of students who were interviewed a year after they had started nursing children, and who have spent time working with pregnant and birthing women as student midwives followed by six months in mental health and psychiatry settings, have had the benefit of reflection to recognise how their resources have changed.

Researcher: Have you found that there’s any difference in the way you can manage and be with mothers - this time round [in comparison to last year]?
Student 1: I think so. I think psychiatry has helped quite a bit... I think you're more aware of what the mums are going through. Whereas in the third year it was exciting working with the baby, and it was almost easier to forget about the mother and just focus on the baby. Whereas now I think consciously the whole time: where is this mother coming from? How is she feeling?
Student 2: It's not that last year you were excluding the mum, but our focus was children, and it was just children. And for me, from the research that we've been doing and midwifery, you become so much more aware of that mother-child bond, and that instinct between the mother and the child. And I think that it just becomes more obvious. It's not a child coming in, but it's a mother and child. So you don't see the child as just a child.
Student 2: And I think also our inter-personal skills have also improved. As in reflecting on their feelings or whatever...
Student 3: It's not as scary now to ask them how they're actually doing.
Student 2: And I think also for me, being in a more senior position has made it easier. You have a bit more of authority. You're not just a nursing student, here to learn about babies or children or whatever. You have a bit more of whatever it is that you need to sometimes get the answers that mums might be asking.
These data indicate the resources that certain experiences allow students to bring to the encounter of nursing children. A capacity for empathy is an important quality of this resource base.

As has been shown, the relationship with the mother is not initially a comfortable one, for many reasons. Students, however, become more accustomed and comfortable within this interaction, yet there are certain features that continue to challenge the student.

This process of connecting by being in relay with a child's mother requires inner strength and is invariably accompanied by fatigue. Starting to understand the difficulties surrounding the child's condition and the family situation and recognising their own inability to fix or sort these out, sometimes leaves students feeling helpless and unable to offer hope.

They are therefore more likely to connect with a mother who is similar to themselves in some way and apparently coping. The most difficult mother to engage with seems to be one sitting with a child who has an unknown or poor prognosis. One student describes that her next challenge, toward the end of her 4th year placement, was to engage with mothers whose children are dying. She talks about having to gather courage for this. This is a different kind of courage from that which she had to mount earlier in her experience of nursing children. The reason for this is that she now comes without knowledge to impart to the mother. Knowledge could take the form of information or experience. She expects that the doctors should be clearer about their decisions and take definite action or decide not to intervene and that this would help the mother:

I was feeling so frustrated at the inability of doctors to make decisions and stick to them - this poor mother was so confused and did not know what was happening and the doctors had no real answer to give her except that they were "trying".

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There is also their perspective as the outsider or the one empathising with the mother and watching her look for signs when she is unable to verbalise her fears or questions.
This is especially true in the case of a dying child. Continual intervention is seen as hope giving, an indication that there are treatment options and thus there is hope. The student is in a particularly difficult situation in these settings, as she fears that she will be questioned and will not know what to say (not have the knowledge). A closer relationship with the mother puts her at greater risk of being asked questions and yet there are some students who will place themselves knowingly in such a relationship. This is not something that the data reveals often. In the 4-year period of data collection, only one student articulates this. Sometimes indignation or anger fuels these engagements. The mother, like the nurse or the student, is in the place of less power, but the student seems more able to fight the battle for the mother or child, even though sometimes only in her reflections or intentions:

One of the greatest challenges in nursing children for me is caring for terminally ill children. One of the reasons why it is so challenging is because of the family who often require as much if not more care love and support as the child. As nurses we are so focused on making people better that we often feel overwhelmed and powerless when we can't. There is nothing one can say or do to make things better in the face of such pain. This is the reality that often causes nurses to distance themselves from their patients. However, when we understand that we are not responsible to take away the pain and that the child or family is not expecting this, then we are able to care, share the pain and provide support without being overwhelmed. With this being a tertiary hospital I experienced many situations where I knew that the child was not going to get better or go home. When I learned to tolerate not knowing, not curing, not healing but accepting the reality of my powerlessness, then I experienced the profound meaning of true caring.

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In conclusion, this strategy of puzzling out connection which has emerged as being *in relay with the child’s mother* is most likely to occur in the context of a student who may or may not like children but recognises her resources and who encounters a child whose mother is present. The student may not be able to communicate with the child directly, but recognises the mother as the child’s resource. Intervening conditions include the student remembering her experience of being a member of the nursing team and her interpretation of those present is often that they have the information and expertise required to share responsibility for the child’s care, relieving her of this burden. The conditions which are most likely to cause her to act in relay with the mother, would be the understanding and expectation of the mother’s role and responsibility, which depends on the confidence and empathy she has gained from her experience base. [see fig 5.6]

In learning to work with people, especially caring for vulnerable little ones, there is also the student’s choice of not engaging and this action has been called *distant doing*. Although completing the task is the goal for all students, this choice of action is one in which they may briefly interact with but do not engage the child.
Puzzling out connection through *distant doing*

- Remembering: Student remembers the routine or rules rather than childhood experience.
- Anticipation: Student perceives resources as insufficient.
- Encounter: Student avoids interacting.
- Others Present: Student feels part of team although sometimes intimidated.
- Connection: Playful connecting, Dutiful safeguarding, In relay with mother, Distant doing.
- Responsibility & Knowing: Student sees responsibility as getting the job done and knows what to do.

Fig. 5.7
5.4. Distant doing

*Distant doing* is the action seen as students find and follow the routine of doing. (Illustrated in Figure 5.7) In terms of a game, this may be likened to drawing the hopscotch lines and then watching the others play. This player may redraw the lines as they become faint, making sure that things are in place for others in the game, but not participating themselves. Other players may each be doing what needs to be done with little apparent thought and without making adaptations to the playground.

This is the option of doing the task, which comes as a result of choosing not to engage. In this "doing", students may acknowledge a child, but sometimes the task is completed without any apparent interaction. This was observed in various circumstances including changing a baby’s nappy, administering medication or measuring vital signs. The purpose of the action is clearly getting the task done, rather than engaging. This action is evidently related to the student’s resources at the time of the encounter. The child is not seen to contribute to the context. The routine or the "rules" dictate the timing and the actions. Sometimes the only purpose is to see the task done and the student, like many of her fellow workers, will do it:

Today I was solely responsible for an entire cubicle. I couldn’t believe that the Sister would do that to me. In the end, however, I managed perfectly. Everything that had to be done was done and I did it all by myself. I was even able to spend time with my patients before my shift was over.

This example brings the added aspect of inexperience to the choice of action. The cause of the action here is the student’s overwhelming sense of not knowing, but having to carry a responsibility of which she is afraid she is incapable. She adds that she could spend time with children, whom she calls “patients” in a functional way, almost as a reward, rather than in the context of her work. The “doing” which she knew the sister could measure, was done. This could be followed by “time spent” as a separate action.

Sometimes the sheer complexity of interaction will cause the student to avoid interaction.
I know there was a new child also expecting a liver transplant who came in, and immediately the sisters and the staff said: be careful what you do around that patient because the mum and dad, they check up on everything. They check the blue board (prescriptions); they check the scene; they check everything. So immediately staff go in and think: let me just get this done and get out of here... It usually gets the nurses' backs up and they just do what they need to do.

Of course, an element of spite or passivity may operate in a situation which students seem unable to change. Here it is ascribed to "interfering parents". It is also seen in relation to diminishing staff allocated to shifts or relational difficulties with the nurse in charge or management. I once saw a student use this strategy with a child when she was angry about my interaction with her. I only saw the anger later. In her journal she wrote and told me of her feelings of being questioned while doing something I was not there to assess. Containing her anger used all the resources she could muster on that day and so she could not then engage the child or me.

This lack of resources is a common cause for distant doing. It is often related to students' fatigue or their not feeling well. It is also related to the energy consuming work of puzzling out their own responses and feelings:

☐ Today was a complete nightmare! I was transferred to the ward next door because they were short staffed. There are +/- 40 children ranging from 18 months to +/- 16 years old.
I was feeling unwell and emotionally and physically it was hard for me to cope with the demands of crying babies with dirty nappies (diapers), hungry tummies and lonely hearts.

Any hint of intimidation from those present could be an influencing factor in choosing this option of distant doing and doing according to their rules.

☐ I was working with the nurse "who doesn't like BSc's"(students on the degree programme). I thought I was going to have a bad day but she told us right from the start that if I charted everything and didn't leave anything unfinished, I'd be happy - and so the day worked out fine.

Later this same student reports the conclusion to this shift:

☐ In high care I at least feel more "together" - I know what needs to be done - to whom and when. By the end of the day I feel satisfied though. I have left nothing unfinished and the children are comfortable and happy (to a degree)!!
This statement indicates how *distant doing* has to do with finishing the task. The student also gives us a glimpse of the consequences of this mode of doing. Like the next student, she may not connect directly with the children, but she still uses their behaviour to gauge the success of her intervention:

- I think a lot of it *(the learning)* is just: that it has to be done. So I'll get on and do it. And you know by sort of finding out maybe it wasn't that bad. Maybe I did this wrong and the child is actually still alive and still smiling at me. P4.1 Focus2.doc 135-141

Watching carefully and not connecting is another way of gaining information and learning:

- Student: I think you can learn a lot from just watching the child. I mean without necessarily being involved. I mean it also means that you're spending time in the area - with the child.
- Researcher: I wonder whether you can connect by watching perhaps?
- Student: Not to the same degree as you can connect if you're actually interacting with them. Because they are not going to connect to you. P4.2 Focus2.doc 542-552

This student indicates what is probably the key to this mode of connecting and this is watching or doing without reciprocity. She could do something for a child, even 'see' the child but she does not receive or expect to receive anything from the child.

**In conclusion, distant doing** is a strategy of puzzling out connection in which engaging is avoided. It tends to be used by a student who perceives herself as having insufficient resources to relate. She may or may not like children, but in this low ebb of resources she avoids interacting with the child whom she encounters. Intervening conditions would include the student's remembering the rules she receives from others and sometimes feeling intimidated by those present. She perceives her responsibility as getting the work done by the rules or established routine and this is the main causal condition for *distant doing* [see figure 5.7].

Data in the category indicating this choice of action were gathered and analyzed with equal rigour to data indicating other choices that were more exciting to watch emerging. The recognition that these students, working with children, learned in the context of their relationships with one another was so exciting to discover that I could have overlooked this last strategy.
Its traces throughout the data were, however, too distinct to ignore. In working with the students and the data, I have also become so aware of the extreme ache and exhilarating pleasure they derive from this work and learning that it is no longer difficult to describe this as a real and legitimate action.

_Distant doing offers_ perspective and reprieve, it affords space in which to measure the concrete aspects of a student’s own progress. Children’s charts filled in with the correct colour ink at the end of each day or a cubicle of quietly sleeping babies, all with dry diapers and reports written are a visible indicator of a day’s work successfully done. This also applies to the more easily measured aspects of their own learning. Skills assessment charts filling up with the required assessor’s signatures and assignments written and submitted all add to the measurement of progress.
Section 6: Consequences of puzzling out connection

The students' actions, described in the previous section, have different consequences. These can be summarised as follows.

The actions:
- playful connecting
- dutiful safeguarding
- in relay with child's mother
- distant doing

result in

OR

getting done
which offers satisfaction by:
- Students confirming their competence
- Students able to record the action and have it done in time

getting done by engaging
which offers satisfaction by
- Students getting to know another person (in the child and his family),
- Seeing the reciprocity of relationship,
- Recognising their significance and the solace it brings.

The central most important consequence of puzzling out connection for the students is satisfaction. Whether they have engaged with the child or have got the task done, satisfaction results from the action. As the discussion of distant doing indicated, the students look for measurable success factors. The satisfaction they report is related to being able to record an activity and that it was done timely. This satisfaction adds to the student's confidence by confirming her competence and therefore adding to her resources. It increases her knowledge and adds to the experience she can use for comparison in the future.

The consequence of connecting called getting done by engaging also brings satisfaction for the student, but analysis reveals that it is richer than the measurable outcomes of merely getting done. They describe their increasing sense of competence to relate to the child and their recognition of reciprocity in the relationship - called engaging.
Students' initial motivation as they approach a child is puzzling out a connection. The measures of satisfaction are about establishing relationship with a child, by connecting and understanding him.

Lionel, Stan, Dina, Sia..... etc etc etc in the last weeks they have all become such special people, all unique. Its as though I have slowly developed an understanding of why and how and when.

In this, of course, they become committed not to hurt but to minimize the discomfort for the child. As they maintain their relationship, they get to know the child, their specific needs and preferences. They gain information not available in the child’s notes or on the routine hand-over rounds. This assists them in meeting the child’s needs in ways that have not necessarily been prescribed.

The engaged relationship is also the context in which they consider saying goodbye and manage to say it:

A difficult part of this week though was preparing the children and myself to say goodbye.... Its so easy just to pretend that they haven't started to mean as much as they do and just walk out that door.

Knowing the child brings the recognition of reciprocity in the relationship. They recognise the different indicators of communication from the child. They learn that falling asleep indicates that they have comforted the baby and that a child who remembers their name indicates that they are known and have been missed. It is in this that they find solace. They are afforded the comfort of knowing that they have contributed to making something about a difficult situation better.

This student’s feeling of worth and value, knowing that her time was well spent and that she had done something of significance, are all clear in this expression of the consequences of engaging.

I was able to devote my time to one special person who really needed it. I had an inner sense of satisfaction and worth because I had been with someone at a vulnerable time in their life. It was difficult for me to leave at the end of the day because I didn't want to say goodbye.
Saying good-bye, especially after having met and cared for a terminally ill child for a whole day, is one of the risks of engaging. Another risk is certainly the risk of being rejected or failing.

I think that my feeling of competence has also been developed by a conscious decision to spend time with the children with the intention of creating some sort of bond or attachment. Let me explain this: by spending time with children I am learning how different children respond to me and how my behaviour can elicit different responses from different children. If we only spend time with children who we know are responsive and easy to be with then we will never develop the skills to engage with difficult, withdrawn, depressed children.

Students are not always able to describe their engaging or the consequences of connecting. I observed this interaction while with a student in a ward setting:

It's an interesting thing to see the student going back to the nine year old boy that she said she was just feeding because nobody else would and he was a difficult child. And interestingly there was an obvious difference in how she could now be with the child. She said she must take his temperature and she is not sure how, so she's going to just do it. He was pyrexial about an hour ago and she wanted to check it after the anti-pyretic. She picked the child up and said: 'No, he is too tall and he is kicking me,' then she wrapped him. Picked him up and held him - one leg between her legs, leaning him against her shoulder. And she comfortably sat back, commented on how relaxed and quiet he was. And then the child smiled at her! Well! This non-verbal, apparently non-communicative child with cerebral palsy, who had indicated no emotion but a high pitched cry since his admission...responded! I could just see for her it was wonderful. I left them sitting like that -- it was so good to see.

These kinds of rewards bring the recognition of reciprocity and a large measure of contentment. On that afternoon, this young woman, knew beyond doubt that she had made a difference to one boy.

A particularly reflective journal entry concludes this section of what students do as they learn to nurse children:

As I look back on caring for ill children during these last two months... I have realized the importance of courage, humility and risk taking in nursing. Engaging with children somehow, for me requires greater risk taking than engaging with adults. There seems to be a wider space of "unknown" with children which requires real interaction and relationship before mutual trust and connectedness can occur. Nursing children requires abandoning inhibitions and giving all yourself to the relationship because children need all encompassing care from people who are willing to engage fully and completely. My ability to interact with children and parents has undergone tremendous growth during the past two months.
In the beginning I was not ready to put all of myself into this process because so much of myself was carefully guarded and kept hidden away and protected. I was able to meet physical needs and "do my job" but did not experience the profoundness of true relationship. I was trying so hard to protect myself and my vulnerability that I did not have the energy to take risks and put more of myself into the process of "learning to be with children".

The analysis of this section of the data has led to an understanding of a quality of relationship I call *engaged relationship*. It is clear that there are three characteristics of engaged relationship. Firstly, the student knows the child. She has acquired this knowing through relating and being present in their interactions. Secondly, she recognises the *reciprocity of relationship* and is encouraged by this. Lastly, she is touched by her *sense of significance* and finds solace in her care of the child. Engaged relationship can result from any of the first three modes of connecting. In the preceding quote, the student finds the courage to care in this space of engaged relationship with a child.

6.1 How do the consequences of puzzling out connection affect the following encounters with children?

Puzzling out connection is not a linear process for students. Each encounter with a child offers the student a rich context for gathering resources, recognising others, gaining knowledge and experience to contribute to the process of puzzling out connection with a child at the next encounter. The consequences of puzzling out connection, as indicated in the discussion of what students do to connect, lead or add to the conditions that will influence their subsequent puzzling out and interactions with children.

The consequences of puzzling out connection that become or contribute to conditions which will influence connecting in subsequent situations are the following:
Consequence of connecting could add to or deplete a student's resources. The student resources which have emerged from analysis include empathy, hope, confidence a sense of inner strength and affirmation or confirmation of how she feels about herself. Connecting with a child could either leave her with a sense of hopelessness or it may strengthen her resolve to engage with another child. An engaged relationship may confirm her confidence in her abilities and bring a better understanding of the situation.

Consequences of connecting could increase or change her knowing. It is clear that a student's knowledge and understanding gained in one encounter with a child can contribute to her remembering and to her knowing in the next situation. Experience gained in a certain situation may also help to adapt or modify set patterns or beliefs a student may hold. This could change the causal and influencing conditions in her next puzzling out connection.

Connecting increases her experience and this affects the intervening conditions of remembering as well as knowing as it helps her refine her thoughts and ideas about herself, her practice and others. This is an important finding in a relational model of learning. If the student is able to experience and reflect on her interactions with other people involved in the child’s care, she is able to clarify and refine her expectations of these others. She is more able to identify and receive their support as she learns to trust their guidance and her instincts.
6.2 Conclusions about puzzling out connection

As students learn to nurse children they puzzle out connection. Their motivation is not merely to learn how to do things with children, but essentially how to gain the child’s trust and to do these with the least discomfort to the child, while also retaining that trust.

The process starts with what the student anticipates, and moves through her encounter with a child or children to the time when she undertakes connection with the goal of getting done. This is with the purpose of completing the required task and may or may not lead to an engaged relationship with the child.

There are clear actions a student may choose in connecting with a child. She may playfully connect with the child, she may dutifully safeguard or choose to act in relay with the child’s mother. There is also the option not to engage and this is called distant doing, as the purpose here is doing rather than interacting.

The student’s resources as well as whether she likes children or does not, are the contextual conditions. Encountering the child adds to the context by virtue of what attracts the student to the child. This includes those factors that distract the student or cause her to avoid the child. The presence of other people, as well as what the student remembers either help or hinder her puzzling. The factors that are most clearly causal in the mode of connecting she chooses, are her sense of responsibility and what she knows about the situation.

Rather than this being a linear process, each puzzled out connection with a child contributes to the student’s resources, knowledge and experience base. This equips her for the next child and situation she faces.
CHAPTER 6

Puzzling out connection:

the discussion
"...students learn in diverse and wondrous ways, including ways that require neither a classroom nor a teacher!"

Parker Palmer 1998: 6

By the end of this study I, like Parker Palmer, have no doubt that students learn in diverse and wondrous ways, including ways that bypass the teacher in the classroom and ways that require neither a classroom nor a teacher!

This chapter invites the reader to join a conversation through which I have attempted to weave the threads of the findings of this study to contribute to the discourse of nursing children by connecting in relationships.

As a novice teacher I set out to understand how students learn. I thought that this understanding would ‘teach me’ how to create the conditions in which they could learn. As with most complex and wondrous endeavours in life, I have come to understand that there is much more about learning than one can hope to grasp in one inquiry. Meanwhile I have come to see that:

Learning to nurse is about learning to connect.
Connecting allows students to become a little more whole or a little better at ‘doing life’, it is about becoming confident and more able.
Learning is about connecting with children and their parents, with peers, with teachers and other caregivers.
As they learn, the students interchange these defined relational roles: sometimes students are children, sometimes mothers, sometimes teachers and at other times, students.
As I tracked the process of student learning, the students’ relationships, probably taken for granted before, have become clearly visible to me. I have watched how they work out how to recognise rules and how to play the game well.

In a phenomenological study, Cheryl Tatano Beck (1992) explored the lived experiences of student nurses caring for exceptional children (as she describes mentally and physically handicapped children).
This study brought new insight to the existing knowledge base especially regarding how student nurses related to these children whose handicaps prevented connecting with or caring for them in familiar ways. The reciprocity in relationships between students and the children was well described and the unanticipated learning that occurred for students in these relationships was confirmed in the present study.

Although the central question in this study was how student nurses learn, the relational aspects of the process may have been anticipated in the light of Beck’s findings. In working out how to nurse children, it is clear that connecting with them is central and that nursing care is the purpose of this connecting. This aspect is a distinctive feature, one I had certainly not noticed as students worked in settings with adults. The students’ repeated referral to children’s honesty is more often related to the child’s non-verbal expression of pain and discomfort than to the things they say. As students compare nursing children to nursing adults, their experience is that adults are more discrete, or perhaps dishonest, about how they really feel or how much it really hurts. So students want to connect ‘without hurting’ or disrupting the relationship with the child. They thus connect by finding the most familiar relational role or way of connecting. This may be either a mothering role or a friend role of playing with the child. Although the prospect of working with ill children is a serious one, play remains a familiar way of engaging with children. The four modes of engaging with children that have emerged in this study, playful connecting, dutiful safeguarding, in relay with the mother and distant doing are constructs which add to a theoretical understanding of students’ interactions with children. These will be woven into the discussion.

The path through this discussion
The previous chapter is a description of what it is that student nurses do as they learn to nurse children. This study was an attempt to observe student behaviour in a naturalistic setting. It can of course be argued that the setting was not entirely natural as the observation occurred within the context of an established curriculum. Here a particular philosophical basis and a commitment to development of individuals ensured a relational support base in the activities of learning directed by the teacher, also the researcher. Chapter four explored these aspects of the context extensively and familiarised the reader with the setting. The obvious question to follow is “so what”?

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How does this description and interpretation of student actions inform the body of knowledge in nursing? This chapter will set the findings in the broader picture and is followed in chapter seven by an exploration of these in the context of teaching and learning.

The guiding methodology in this study has been grounded theory, a method that has at its heart action or interactions (Strauss and Corbin, 1990:159). It allows the researcher to examine the observed actions and interactions in relation to the specific context. Various conditions contribute and consequences ensue, all these contribute to what is described as a transactional system. The researcher is encouraged to track the complex web of interrelated conditions in analysis. The discussion of the phenomenon - puzzling out connection - emerged as central to learning about children and was tracked in the previous chapter. As can be expected, these relationships with children, students’ actions and interactions, also occur within a complexity of societal conditions. This broader discussion has been organised by systematically considering four of the levels in which these relationships may occur.

The use of a conditional matrix in analysis enhanced the outcomes of this study by encouraging the researcher to consider the conditions in which the interactions occurred at many different levels. This concept of utilising concentric circles to represent different aspects of the world around us is also useful as one weaves a path through the discussion of the emergent substantive theory of how students learn to nurse children.

philosophical milieu

caring work with children

adolescent learners

actions of connecting
The first level, which may appear to be furthest from the students' actual interactions, is also very close. It can be called the philosophical milieu where current thinking is affected by prevalent perspectives. This study took place between 1995 and 1998 so that the context was not only a shifting, unsettled democratising third world setting - described in Chapter 1 - but also, a shifting theoretical and practice context. This will be explored in the context of current literature.

The second level of discussion will consider the nature of caring work with children. Learning to nurse children in this study happened in this broader context and therefore bears discussion. This will be woven into the current discourse about children, their vulnerability and endearing qualities, as well as that about caring for and with mothers.

The third level is the consideration of the nature of students in the life stage of adolescence. The current literature will contribute to the discussion about adolescents, their learning and particular perspectives, resources and relational experience in this life stage.

The fourth level is the level of the actual interactions between students and children in this study. Although the four ways of connecting with children are woven throughout the discussion, the specific aspects that surround learning in the modes of interactions will be considered here. This will include the modes of action and interactions they choose as they connect with children. This will be complemented with discussion about the nature of resources, responsibility, remembering, knowing and the others present.
Section 1: Shifting perspectives in thinking and practice

Paradigms, or the way we are used to thinking about things, are not unlike sand dunes in a desert. Just beyond the northern borders of South Africa lies a majestic and foreboding golden orange desert called the Namib.

“At any given moment, somewhere in these dunes, which stretch as far as the eye can see, the unfailing wind is whipping sand up a slope and over its crest, from which a gritty tongue of sand is cascading down. Billions of sand grains are in motion on the surface of this windswept land, piling high into newly formed peaks and realigning the contours of the dune-studded valley below” (Arritt, 1993:156)

Human thought, dialogue and endeavour are not unlike the unfailing wind in whipping at the formations of how we think about and do things, stirring at the shapes and changing the contours of our understanding and perceptions. In the last decade or two, it seems to me as if the wind has sped up, maybe even reaching gale force. Ideas move from one continent to another: they meet at conferences and via electronic mail as we connect and share visions and plans. Innovations seem ‘made to fit’ into whichever corner of the globe they are replanted. Like in a desert, “…that which seems eternal may change overnight, and that which is least expected is always a possibility” (Arritt, 1993).

If these winds take a little longer to reach Africa, that fact has both a positive and a negative side. The positive is that the treasures and wisdom of African thought and living can be recognised and portrayed as an addition to the winds that shape current thinking about health, health care provision and learning. To our detriment is the fact that the winds of western thought and culture have so strongly swept the land that we may still be in the sandstorm of confusion prior to the new contour settling.
I would like to suggest that there are three shifts which impact how student nurses learn to nurse children in this setting at this time.

- shifts in perspectives of the nature of persons: between individualism and communalism
- shifts in health care provision: between ‘doing to’ and ‘being with’
- shifts in education: between objectivism and co-operative learning.

Shifts in the paradigms are no small or rapid occurrence, probably because human beings hold them. Schluter and Lee (1993:264) maintain that once something new “...emerges as a dominant colour in the seamless weaving of time […] it will be recognised and may be reflected on, idealised and put to use”. In a paradigm consisting of beliefs, values, techniques and canons shared by members of a given community (Kuhns 1962 cited by Rentshler and Spegman, 1996: 389), a shift has occurred when thoughts, perceptions and values change and a new vision of reality emerges. As these authors explore their nursing curriculum and paradigm shift, they describe such a shift as a rather linear process. Starting with the recognition of discomfort, through increased external influence urging change, the process moves to perceive crisis and intense dialogue before finally there is a move to acceptance of the new paradigm (Rentshler and Spegman, 1996:390). I would like to suggest that while these shifts are being negotiated, the ordinary people or members of the given community experience the uncertainty. They are either being whipped to the crest or cascading down like the sand on the shifting dunes, - theirs is a process of to and fro rather that linear motion towards resettling.

1.1 Shifting perspectives of the nature of persons: between individualism and communalism

In South Africa, as in the rest of Africa, the paradigms of Western individualist thinking and African communalism provide the backdrop against which people seek to understand everyday life, politics, economic decisions and ways of being. This too is the milieu in which students and children in this study live and learn. Their interactions are inevitably related to how persons are valued and regarded.
African communalism is espoused in the worldview called ‘ubuntu’. The Xhosa version of an African proverb illustrates this. ‘Umuntu ngumuntu ngabantu’ is translated, ‘A person is a person through other persons’. Goduka (1996) emphasises that this African worldview is based on collectivism rather than on individualism. Unlike communism or socialism, this collectivism describes an intensely community-based ethic, with the focus on the group rather than on the individual. The group is the extended family and the clan and includes the ancestral spirits. Goduka offers a perspective on the African community by interpreting the proverb as meaning:

“I am because we are. We are because I am.”

The ‘I’ is a single person in African culture who is as related to his community as he is to himself. The person therefore sees the community as an extension of himself and exists because of the community, and shares a common identity with the larger group. This affords the person wholeness and a sense of belonging. This kind of understanding and collectivity is the norm in many of the cultures which comprise South African people, not only those who are black or live in rural settings.

Childrearing before western colonisation is portrayed thus by a Ugandan lecturer who describes herself as a feminist sociologist. Identified only as ‘Sarah’, she explains that in rural communities, children saw little of their parents while growing up. “Once weaned their time is spent among their own age group, supervised by those directly above. Children may move to live for a while with a grandmother or other relatives” (Murphy, 1993: 98). In South Africa this practice is still prevalent and often understood to be related to parents’ (most often the mother’s) employment or schooling in an urban area. Within an extended family, children have many more important adults in their lives than the average Western child does. Thus the obligation to provide mutual help of every sort is understood from an early age. The sense of responsibility with which students grapple in this study needs to be seen in the light of this understanding.

Most of the students in this study had received what would be termed a western schooling. Growing up in an extended family setting was however common and not only to black students. One of these students was living in an extended family setting at the age of six, when her mother died. At the time she was told by the rest of the family that her mother had gone to Johannesburg.
Her grandmother subsequently told her about her mother’s death when she turned twelve. Discussed on the nursing programme, this incident brought exclamations of empathy from some of her peers. Many were outraged that she had been ‘lied to’, but to their amazement the student replied that it was not an untruth because it was ‘right’. In the extended family the six-year-old had different expectations of support.

Different understandings of bereavement are but one example of how different ways of thinking about people and belonging must be negotiated in learning to nurse. In explaining a Westerner’s puzzlement about Africans’ reactions to bereavement, Sarah’s husband reports: “... some think we are very brave, some think we are unnaturally fatalistic, others think we’re callous - and hint maybe that’s to do with being primitive. Which is correct, if you like to call our traditional society more primitive than yours. The various tribal initiation ceremonies were partly endurance tests and very severe. From earliest childhood everyone was trained in all forms of self-control, not just to do with physical courage. Even now good manners mean not showing emotion, whatever stress you’re under” (Reported in Murphy, 1993:100).

Contrasted with communalism, the idea of an individual seeking self-actualisation and fulfilment remains one that few Africans would reject. Yet a Tanzanian academic is quoted as saying: “In a way all Africans have been messed up. I am the third well-educated Westernised generation and no one ever tried to squash my individuality but I still have a foot in both camps. I could be scared by things that would make you laugh if I confessed these [...] Any African who tells you he has both feet in the Western camp is lying” (Murphy, 1993:100). In a recent conversation that the present author had with a South African Professor of Nursing, this perspective was confirmed to be true for her personally and in this country. This adds to the discussion the understanding of what Goduka (1996) means when saying that the sense of belonging to the group includes not only the extended family but also the ancestral spirits.

A communal ethic has relationships at its core, and as such broadly affects the way people think and act. Children apparently abandoned to hospital care often have complex stories. This little three-year-old had AIDS and had been described as abandoned 6 months before:
Sylvia’s grandmother visited her today. Apparently her mother’s boyfriend was the carrier and even though the grandmother said that Sylvia’s mother’s test came back negative, I believe otherwise. She, the grandmother is aware of the fact that Sylvia will eventually die. It appears as if Sylvia’s mother is too upset to visit her child.

The way that Africans think about health is a good example of how people think and act in this communal ethic: health is symbolic of correct relationships between people and their environment. Health is associated with good, blessing and beauty - all that is positively valued (Clements, 1978). This child’s illness is much more complex than an infection. Broader definitions of health have also entered Western thinking: “Health is inherently communal. [I]t is difficult to understand an individual’s health apart from those things that make a person coherent, whole and meaningful” (Gunderson, 1997:5). Students in this study may have been exposed to this type of definition of health as relational or communal, but a century of Western thought has layered people’s thinking with different expectations and aspirations. In settings of care they are often pressured to provide technologies rather than relationships and this can result in a conflict of values.

In South Africa the legislated ‘separate development’ of apartheid violated a central tenet of human society namely relational proximity. Not only did its policies inhibit freedom of domicile of black people and separate families forced to rely on migrant labour of bread-winners, it also kept black and white South Africans separate, not talking to one another and probably both believing that individualism was a better and more sophisticated way of being than traditional communalism. As dialogue was precluded, relationships between one another and understanding of these different ethics could not influence the nature of society. The formal sanction of the Western worldview was embedded in structures of education, medicine and commerce and geographic separation still affects how people perceive themselves. It affects their sense of belonging or achieving and how these attributes of persons are valued.

It is within these shifting understandings of persons that students find themselves. Whether they are black or white Africans, they begin to understand the differences and similarities between cultures as they learn.

Relational proximity is defined by Schluter and Lee (1993) to mean a closeness of relationship between individuals, through which each is able to recognise the other more fully as a complete and unique human being.
They work with children who are growing up with different ways of becoming persons in their own right. One child may call his grandmother "ma" and his biological mother by her first name, while another is inseparable from his biological mother, and yet another seems unperturbed by his mother’s absence. I suspect that there are students who, in negotiating their way through these shifting dunes of understanding, would identify with Dervla Murphy (1993). She describes her experience of trying to understand the apparently distant behaviour of a set of parents with a distressed little boy in a paediatric ward, in Kampala:

“But while I had wondered, peering across this culture chasm, why there were no caresses and murmured endearments, none of the outward signs of loving sympathy that we would lavish on a sick child, these parents were of course going through hell, but by a route I did not recognise.” (Murphy, 1993: 99)

In learning to nurse children, finding one’s way with people is a constant challenge. Trying to understand the language, trying to work out how to respond to behaviour that is different from one’s own or sometimes familiar, without embarrassment or judgement, is the way of puzzling out connection for these students.

So they may choose to befriend a child because they understand about being away from family, or fiercely guard a child because they think he has been abandoned. Sometimes a student’s confusion in a situation may lead to doing the tasks with apparent distance or her relief at seeing a mother arrive will cause her to hand on the baton.

1.2 Shifting understandings of health care provision: between ‘doing to’ and ‘being with’

This paradigm shift is certainly evident in writings much further afield than Africa. Health care provision is influenced by certain central theoretical underpinnings, most notably those of medicine, pharmacy and nursing. Societal values, health care practices, structures and the nature and extent of the available resources further affect health services in any country.
Current health care provision in most western countries and until recently in South Africa, seems to have taken its form largely from the scientific perspectives of medicine. Tracing Western health care through pre-Christian times to that practised in the monastic system, the parish system, the work of white ‘witches’ and the good wife of the house, through physicians and barber surgeons to current care, places this in a broader perspective. Health care is now provided by trained doctors and nurses based mostly in the scientific paradigm. This paradigm can be traced as influencing health care provision in most western care settings and also in South Africa. The theoretical frameworks of nursing from as early as Nightingale in the mid-nineteenth century to the present, would confirm that “[t]he key component of [care received in] the health service remains a relationship with a health professional (Relationships Foundation, 1996:2).

Traditional Western medicine concentrates on diagnosis and treatment of illness using approaches informed by the positivist scientific paradigm to predict and control disease. This perspective is based in Newtonian thought, in which the world and the human body are seen as mechanistic and made of different parts. It has resulted in hospitals being established with departments and specialists for almost every body system. The concept of germs causing disease added the idea that disease had an external cause, an agent that needed to be eradicated, usually with drugs or surgery (Holford, 1998:9). These understandings mean that people began to see health care as applied: it is something which is ‘done to’ the person who requires care. Although this approach has produced some positive results, it is becoming more widely recognised that its methods are insufficient for much of the chronicity and ill health faced today. This is true in both first and third world settings.

The way nursing is conceptualised and practised in South Africa, like in Canada, the USA and the UK, owes much to how it has been formulated as a science (Nicholl, 1986). The term ‘nursing science’ first entered the literature in the 1950’s. During this time it progressed largely in accordance with the positivist philosophy of science (Cody, 2000). The methods of science were viewed as capable of eliminating errors in judging what is factual and true (Chinn and Jacobs, 1986:3).
Relying on this and their caring intentions, nurses adopted the scientific problem solving process of medicine - assess, name (diagnose) and manage - to guide not only physiological care but relationships with people and families who are recipients of care (Mitchell and Cody, 1999:105). Although Cody describes nursing in the 1950’s as subjugate to medicine and “...doubly dominated as a new science led by women” (2000; 93), others describe this as a conscious efforts to bring nursing into “…its rightful place among legitimate professions” (Campbell and Jackson, 1992: 477). The latter remind that through a variety of theoretical constructs nursing science was able to address, if not solve, a number of problems for nursing. In this regard they refer to the work of King (1981), Orem (1985), and Roy and Roberts (1981). Cody, however, records the rumblings of dissatisfaction among nurse practitioners and theorists by the late seventies, claiming that this paradigm was no longer useful in explaining human beings, health and the real issues of practice. Nurses were calling for a change in values to humanistic approaches that emphasise meanings, possibilities and free will (2000: 95). The social sciences already seemed to offer methods that would better capture the actual caring practices of nursing. Although nurse theorists have been conceptualising nursing more broadly or differently, for the last three decades, health care provision in South African hospitals is still dominated by the so-called scientific nursing process.

The theoretical framework for students in this study is that nursing is “...a creative and caring service...[and that] central to the practice of nursing is a commitment to relationship” (Appendix 1). This broad understanding instead of a skills-based understanding of the application of technology, is not often what they find in the hospital care settings. The unreal split between what nurses know and what they do still remains visible in the health care services. Nursing is still fragmented and divided into junior tasks and senior tasks, the latter often being more technical, administrative and further from the patients. So patients can be cared for by a range of nurses with the most experienced doing the less personal tasks.

I expected Sister* to spend much more time with (the children). She’s usually busy in her office or attending meetings... I guess that this is the part she plays in their lives. She sees to it that records are kept of what goes on...
A landmark study by Menzies (1960) is still cited as suggesting that this fragmentation of nursing work enabled nurses to avoid too close or intimate contact with patients - probably for the sake of objectivity. Analysis of students’ perspectives of this, adds a further reason, namely the possibility of nurses’ lack of resources.

Nursing children must be very taxing for staff because it is such a giving relationship. Constant hugging, loving, cuddling, caring and not much in return. It must be quite easy to just clam up and protect yourself by becoming hard.

Further contradictions in students’ experiences of care occur between formal health care settings, informal care settings like families, and play schools. As indicated in the previous section, the African perspective of health and care is communal. This perspective of the importance of social and spiritual relationships is not always welcome in formal health care settings, and this bring further challenges to students’ shifting understanding and learning.

Although the type of health care service usually reflects the cultural values of a society, formal health care in South African society is a distorted reflection of the diversity of cultural values. Students learning in changing health care settings in South Africa face paradoxes daily. The nature of the changes continues to require major shifts in the practice of nursing and medicine, and essentially influences the practice and learning of student nurses.

I went into [an informal settlement*] on my first day with many different expectations: Poverty and dirty houses, sick and unhappy children... very sceptical of community health workers’ ability and knowledge.... Although it was quite an experience going to (people’s) homes and seeing things ...I have had to re-conceptualise all of my biases and preconceived ideas. One thing that I have really noticed is that I am not afraid. The community is relaxed and welcoming, everybody greets with smiles and questions.

Although Mitchell and Cody make a strong argument for recognising the value of both the “...intentional caring presence of the nurse caring for someone” and the technical skills and knowledge brought by medical colleagues (1999: 306), these are often experienced as paradoxes by students and difficult to reconcile. One sums up her struggle of negotiating these shifts as she tries to establish her own way of thinking about and doing nursing.
When I learned to tolerate not knowing, not curing, not healing, but accepting the reality of my powerlessness, I experienced the profound meaning of true caring.

As indicated in the previous chapter, students are often reprimanded for becoming involved with children. Carrying a child or taking him out of the cot merely to play rather than for what is termed a ‘procedure’ was often frowned upon. This could create the impression that distant doing was the preferred mode of caring for a child. It seems that students ‘get away with’ playful connecting because staff see them as ‘young and still learning’. A student who is engaging a mother by being in relay with her, is bound to require additional information which sometimes the more senior staff, with their perception of ‘doctors’ domain’, do not access. In this study the mode of connecting most welcomed by staff, both nursing and medical, seems to be dutiful safeguarding. This confirms the pervading practice of ‘doing to’ rather than ‘being with’ in many paediatric settings.

1.3 Shifts in education: between objectivism and co-operative learning

Education, like health care, is a practice that has become an integral part of the public domain. The attempt to provide some educational experience to more children meant that ‘schooling became an organisational convenience” (Watts, 1991:2). As described above, the pervading paradigm guiding thinking for most of the last century was the scientific paradigm, this necessitated that objectivism, its main tenet, guide the education of its thinkers. The move of education from the private to the public domain at that time meant a move from learning from familiar elders to learning from distant experts. Recent thinking in education from educationalists like Paulo Freire (1988) indicates yet another shift: that of learning from elders to learning with peers.

The reason these shifts in thinking are considered here is that the ways of understanding and approaches to learning are so different in the life worlds of the students in this study. Thinking about education and learning in nursing is related to the philosophical and ontological shifts between medicine and nursing and changing paradigms within nursing, discussed in the previous section.
The locus of learning for students in this study is clearly both the classroom (in a nursing as well as medical and psychology departments) and the clinical learning setting. Here the relationships they encounter include those with the teacher and peers, but also staff in clinical settings, children and parents. In each of these settings and relationships the understandings of learning, sources of knowledge, expectations of students and responsibilities vary considerably as they experience the shifts under discussion.

Education within nursing, as in any field, should be congruent with its ontological and epistemological bases. The nature of nursing or what it is believed to be (ontology) as well as the origins of knowledge about it (epistemology) should be central to how learning to nurse is structured. The current ontological basis of nursing has been influenced by centuries of caring. It can be traced through care given by Sisters of Charity in the 17th Century, to the work of Florence Nightingale in 1860 (Cohen, 1993), to the early 20th century when conventional science was the primary guide to nursing practice (Cody, 2000). As described earlier, by 1970 nursing had developed a clear scientific base and theoretical developments in adjacent fields of social sciences heralded another shift. This time the shift was from objectivist and behaviourist beliefs to humanistic values. While "...behaviourists argued for objective, value free science to achieve social norms, humanists argued for finding meaning in life, preserving human dignity and actualising human potential" (Cody, 2000: 94).

Early nurse theorists who worked and wrote in the objectivist paradigm cannot be underestimated; they were on the frontiers of developing scientific thinking and were formulating the deductive theories that were the foundations of nursing’s emerging knowledge base. The curricula that ensued from the development of nursing as a science were largely based on behaviourist principles. These curricula “...succeeded in producing nursing action as a scientific as opposed to an intuitive or common-sense activity” (Campbell and Jackson, 1992: 479). Although objectivism set out to put truth on firmer ground, “...it also holds that any way of knowing that requires subjective involvement between the knower and the known is primitive, unreliable even dangerous. The intuitive is derided as irrational [and] feeling is dismissed as sentimental...”(Palmer, 1998:52). This loss in nursing is similar to that in education.
In the quest for objectivism in education, "...we separate facts from feelings, theory from practice and even teaching from learning" (Palmer 1998:52). Recent extensive research has revealed that central to the practice of nursing is what expert nurses describe as "knowing the patient" (Tanner, Benner, Chesla and Gordon, 1993). The principles of objectivity do not fit comfortably with the currently accepted ontology of nursing, which is relational and caring.

The shift away from curricula guided by the principles of objectivity in the early 1980's originated with nurse educators' discomfort. They were convinced that nursing theories and education must be congruent with the values of nursing, which was more about involvement and about caring for people. Visionary leadership at the UCT nursing department resulted in the restructuring of the undergraduate baccalaureate degree by early 1984. This progressive model of creative nursing (Skeet and Thompson, 1985) embraced a health, whole person and family focus. This team of nurse educators pioneered a curriculum in South Africa, which could recognisably be described as a caring curriculum. In Europe and the UK thinking and deliberation focused on a shift from hospital to community based care. In the UK, Project 2000 was the first attempt at the implementation of these discussions and changing perspectives (UKCC, 1986).

Meanwhile at a National League of Nursing convention, in the USA in 1989, nursing scholars were initiating what has become known as the curriculum revolution. The 'revolution' favoured the overthrow of authoritarian and behaviourist beliefs inherent in traditional nursing curricula (Bevis and Murray, 1990; Diekelmann, 1990). These scholars had started writing and shifting their curricula and teaching of nurses in an attempt to meet the changing health care needs of the American population. Diekelmann (1990), Allen (1990), Tanner (1990 and 1996) and others describe with passion their own experience of teaching. They express both their triumphs and failures - not a usual practice in objectivist reporting. Instead of writing in abstractions they are present in their writing and the reader recognises the very elements which nursing and nursing education were lacking: authenticity and involvement. A counter-revolution followed in 1992 as nurse teachers cautioned that a sound knowledge base could not be sacrificed (Kessenich, 1992). It seems however that a door had been opened to a myriad of new and different ways of doing.
Developing methods of enquiry and practice in the human sciences like ethnography, ethnomet hodology, critical theory and gender studies contributed to these. Methods of inquiry like grounded theory in sociology and phenomenology in psychology offered expanded ways of exploring and thinking. Nurses became among the most avid researchers in some of these traditions.

Although many authors have written about curricular innovations in the last decade, Walton reports that despite valuing a more caring and relational model in nursing, many nurses are still taught using paternalistic pedagogic and positivist methods (1996:401). In these schools, teacher-learner relationships are often strictly role-based, characterised by authoritarian expectations and professional distance geared towards objective outcomes. This probably has something to do with the difficulties of defining the nature of interpersonal relationships in institutions of teaching.

In South Africa too this is the pervading practice and nursing models have little impact on learning the discipline. This may also be because in this country “...nursing models are only of academic interest and nursing theory is not a requirement for pre-registration curricula” (Kyriacos, 1992: 50). While nurses like Benner (1984) in the USA were finding a new sense of purpose and direction consistent with nursing’s basic values in the early eighties, there is little documented evidence in South African nursing literature that nursing models are applied in practice settings (Kyriacicos and van den Heever, 1999:320). This has resulted in traditional objectivist, often medical models still pervading the structure of curricula and the functional approach to care in clinical settings. These settings are a primary locus of students’ clinical learning and they are expected to work in these disengaged structures, which are very different from the way in which they learned in the nursing department. These expectations often led to frustration and confusion as they work out their practice.

In nursing, it is so easy to go with what is done in a ward and lose the essence of the personal care that nursing should involve... I am finding more and more with nursing children that individualism is so often overlooked. After all every one ‘prefers’ institutionalised children. P3.3journal 133-139

The pressure of how they are expected to learn in this type of setting, can easily prompt distant doing.
Palmer points out another important aspect of objectivism: "As people became convinced that objective answers to all questions were possible - and as specialists emerged who were glad to give these answers - people began to distrust their own knowledge and turned to (so called) authorities for truth" (1998:58). It is in this space of mistrust about whom to believe that students often find themselves, the parents and the children in health care settings. They, along with nursing staff work in practice settings driven predominantly by objectivist thought where value is accorded mainly to interventions prescribed by medical colleagues. Prominent nurse researchers, most notably Benner (1997), are urging nurse practitioners to give voice to what they know as nursing work so that the theory and practice can be re-engaged.

The students in this research study were enrolled in a curriculum which espoused the values of transformative learning, where the premises were that health is the norm and that nursing is relational and aimed at the whole person in the context of their family. Much of their learning occurred in formal and informal care settings in which their course requirements necessitated that they become involved and participate while learning to nurse. They entered a curriculum designed to integrate learning in nursing courses while in their additional courses' teaching was often underpinned by the tenets of objective, reductionism. Subjects like anatomy in 1st year, physiology in 2nd year and pathology and psychology in 3rd year, all demand disengaged reasoning. They experience these differences in thinking as paradoxical. As they come to understand nursing in one way and encounter another way as more academic or valued they find their way with both approaches. Their perspectives of relationship and wanting to connect are often frowned upon and not considered 'professional'.

At the end of the day we have to change all the children into pyjamas and give them a 'top and tail'. I thought to myself "I am going to wash these children and do it properly and spend quality time with them at the same time". Despite all of the black looks and signing etc (from the regular staff), I put each child in a full bath, washed their hair, brushed their teeth and played with them - they loved it and were 'clean'!! Needless to say that I washed children for 3 hours - but knew in my heart I did a very good job and made 4 children very happy and very clean.

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While they work out their own patterns and modes of engaging with children, they, like probably many other students who encounter this theory practice gap, contend with the 'almost but the not yet'. As described before, students' central learning process that of puzzling out how to connect with children is often frustrated in clinical learning settings. While questions may be welcomed, insights gained in relationship with a specific child or mother will seldom find an ear or a space on the 'nursing notes'. Insights gained while in relay with a mother or playful connecting are used for personal learning rather than public contribution.
Section 2: The nature of caring work with children

I have often asked groups of students what their first thoughts are when I say the word 'child'. *Vulnerable* is the most common descriptor offered. The Latin root of the word 'vulnoro' (v) means 'to wound'. The literal meaning of the word which is translated as vulnerable: 'apertus' is open or frank (in Wilson, 1965: 12 & 290).

In one translation of the Biblical text, 'like a child' is described as being trusting, *lowly*, *loving* and *forgiving* (Matthew 18:3 in the Amplified Bible, 1987:1100). This is an excellent set of descriptors to use in the understanding the nature of children and a good summary of those used by students in this study. The way students anticipated children and found substance in their encounters and interactions with children, was often related to the way they perceived children to be. *Trusting* or innocent and non-suspecting means that approaching children with something you know will hurt is difficult. *Lowly* or meek is a characteristic that, along with children's lack of physical strength, makes almost anyone else more powerful in relation to them. *Loving and forgiving* are those endearing characteristics of children that cause them to remember students' names, run to hug them in welcome or reciprocate their approaches and submit to their care and ministrations even if these are sometimes clumsy. All four of these characteristics of children also add to their vulnerability. This is an aspect of leaning to nurse them that often frightens students, with its prospects of responsibility, not only 'to do no harm' but also 'to do their best'.

The children whom students encounter in this study cannot be clearly defined by their ability or condition, unlike the children in Beck's (1992) study who had either physical and/or mental challenges. They can, however, all be described as vulnerable. They include children in hospitals and convalescent homes, in play schools or other settings of care. They are all children who can be described as being 'at risk', the other term often equated with vulnerability. Children are often without their parents and unable to fend for themselves.
Whether students meet children in the places where they live or in public care settings another aspect of their vulnerability was the very high incidence of poverty. While "...emotional and social impacts of family breakdown can be severe, the accompanying reduction in financial circumstances, are associated with poor outcomes for children" (Roberts, 1996:99). This is important to recognise as contextual to the present study.

Work by anthropologists, sociologists and historians indicates that notions of 'childhood' and our sense of what it means to be a child are not givens, but are socially constructed (James & Prout, 1990; Hockey & James, 1993). Discussions of childhood are frequently clouded by ideologically driven arguments, but "...ways in which children are cared for are not fixed laws of nature and there is no monopoly of virtue" (Roberts, 1996:94). It therefore seems that considering the nature of children as vulnerable is a way of plotting a way through this discussion.

Vulnerability as a concept is often understood in its epidemiological context and in public health sciences it is used to describe certain populations who require additional care and resources. Children are included in this subset of populations along with the elderly, disabled persons and refugees. Spiers argues that by reducing vulnerability to an epidemiological term, we reduce our vision of the world (2000:715). She suggests that exploring the meaning and experience of vulnerability from an experiential position (emic view), alongside the more familiar externally evaluated risk (etic view) could contribute to broadening practice and policy by providing new ways of conceptualising vulnerability (2000: 718).

Spiers holds that the etic view describes the characteristics that refer to deficits and are assumed to increase social dependence (2000: 718). The vulnerability of children from an etic perspective yields the understanding that they require shelter, food, safety and protection from harm. These aspects can be objectively assessed. Many international and national health policies are drawn up from this perspective, e.g. GOBIFF.

2 GOBIFFF: A WHO initiative in response to the call for Health for all by 2000, this acronym means: Growth monitoring, oral dehydration, breast-feeding, immunisation, family spacing, food supplements and female education.
This policy publicised by UNICEF denotes the major parameters believed to be necessary to promote the well being of young children and their female caregivers – defined as vulnerable populations in third world settings. Through this thinking, technology becomes the key metaphor for our efforts (Richter, 1997:97). Its major weakness is that such interventions assume that lack of awareness and ignorance are the major barriers to health. The assumption is that health strategies, like GOBIFFF, would work universally, if only recipients of our efforts would do as we tell them to do – “be guided by growth charts, administer oral rehydration and breast-feed their babies, bring them for immunisations and stimulate them” (Richter, 1997:97). The etic perspective has also persisted in nursing and there is a tendency to ‘blame the victim’ rather than the social structures creating and maintaining the vulnerability.

An emic perspective of vulnerability is based on the experience of exposure to harm and how this challenges the person’s well-being or integrity. This view offers an understanding of values like strength and capacity as a balance to the concept of vulnerability. This balance is especially important for those working with the vulnerable, like children, “…who have become set apart and stereotyped on the basis of functional deficits rather than their strengths or experiential qualities” (Spiers, 2000: 718).

Spiers (2000, 719) assigns six attributes to an emic understanding of vulnerability. These will be utilised to guide the reader through this discussion of many of the pertinent aspects related to caring for children and also how these affect students and how they chose to interact with the children. The six attributes in this understanding are:

- the child’s integrity,
- the presence of challenge,
- children’s capacity for action,
- the variation from one child to another,
- vulnerability as power
- the mutuality of vulnerability.
The child's integrity

Spiers uses the term integrity to describe the wholeness of the person. It is similar to the understanding of the whole person in the UCT nursing definition of person (appendix 1). It is about soundness in various dimensions of the child’s life, including relational, physical, intellectual, emotional and spiritual dimensions. The child’s integrity is understood to be about him being well and unscathed.

Five aspects can undermine a child’s integrity and are important to recognise:

- reductionist theoretical frameworks used for understanding children’s development,
- the etic view of children as potential adults rather than current persons of value in their own right,
- each child’s integrity as integrally linked to his belonging and therefore to family,
- mutilation or damage to the child’s body,
- the experience of pain.

The perception that children were merely small adults persisted until relatively recently and theoretical attempts at understanding children as different from adults only emerged with other ‘scientific’ endeavours. These attempts are what Roberts (1996) refers to as ideological constructs: sets of beliefs and practices dictating how children are, should be treated and how they respond. Theoretical understandings of childhood as a social construct are shaped by how a particular society is organised; considerations of family life and notions of community or individualism are more recent. Alderson asserts the trend of ‘staging’ children, started in the nineteenth century as teachers started to teach children of the same age groups together (1993:62). As scientific investigation and reductionism gained ground, the work of developmental psychologists like Piaget (1924) and later Kohlberg (1981) continued to describe the development of young children only in one area of children’s endeavours, e.g. their intellectual development or their moral development. As recently as 30 years ago, these predominantly cognitive explanations carried much authority and it was accepted that hospitalised babies up to the age of seven months do not miss their mothers (!) (Wolf, 1969:52). This was based on the beliefs that as babies were as yet unable to think or reason, they therefore did not ‘know’. In this study data often indicate that children in care settings are still approached and treated as if their emotions and understanding are separate. There is much data in this study indicating the prevalence of the understanding that holding or comforting a child will lead to ‘spoiling the child’. Undermining the child’s integrity in this way increases their vulnerability.
Staff refuse to pick up babies when they cry for attention. The nurse this morning told me to put a baby down because one of the other staff members who was there a bit longer doesn't like it when you pick them up.

Wolf asserts that the "[c]linical detachment of professionals working with children in institutions further delayed scientific exploration in this regard" (1969: 62). While more recent writing offers a broader understanding of children and their development (Donaldson, 1978; Dunn & Kendrick, 1982; Siegal, 1991), it is evident that in the context of the present study these are not yet influencing nursing practice in the clinical settings in this study. This may also be related to the prevailing reality, described earlier, that more academically prepared nurses (registered nurses*) work further away from the actual care of children. Students glean the attitudes captured in these data from auxiliary* and staff nurses*, whose perceptions are based in personal experience and societal practices rather than theoretical understanding. While a more integrated understanding of children may build on the conceptual understanding of the individually, unique nature and integrity of children, limited understanding continues to distract from their care and adds to these children's vulnerability.

Another distraction to understanding children's integrity is the tendency to see them as not yet complete, but rather as potential adults. They are often seen as crude or raw material to be shaped in the production of adults fit for society. Well-meaning diplomats and benefactors establish funds and trusts for 'our children, our future'. This altruistic stance is reflective of an etic perspective, valuing children for their potential, their 'not yet' rather than their 'present reality'. This way of thinking is not always easy to detect in the data and mostly utilised by students to create meaning from suffering or early death. Thinking of how hard it would be for a child to live with extensive disability or suffering, sometimes causes them to become resigned to the death of the child. Students recognise this thinking in others and if the child concerned was one with whom they had connected, others' responses are difficult to understand.

...all the Prof's and consultants came in that evening, while I was sitting at her bedside they were all giving guesses as to how long she would live for... They all looked at me cynically and said "do you know the protocol for these kids?". I was deeply saddened at their approach - they presumed that because I was giving this child love and care, that I would expect them to jump in to resuscitate her when she died.
This etic view of vulnerability, is often one which determines which child receives care and from whom scarce resources are withheld, often a difficult experience for students in this study.

The child’s unique integrity is expressed at a personal level but also as belonging to a family and part of a community. Any disruption in this social integrity increases a child’s vulnerability. Bowlby’s classic study (1953) resulted in the notion of ‘maternal deprivation’ gaining popularity, but Comer (1974) contends that children in Bowlby’s study were deprived of a lot more than only their mothers - also their fathers and families. After an extensive review of recent literature, Roberts urges practitioners involved in the care of children to remember that most biological parents in “[a]ll kinds of family structures, lone or dual, conventional or not, do a ‘good enough job’ in bringing up their children” (1996: 100). This is often hard for students to accept:

...I am sure that some children are traumatised when spending time away from their parents... The difference here is that the child in play school gets to go home, hopefully the parents spend quality time the child won't feel too rejected...however (its) also possible - the parents aren't concerned. Some parents of hospitalised children go to the extent of abandoning the children.

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It is often in settings where parents are not present that the mode of connecting dutiful safeguarding is observed. Understanding the complexity of children's vulnerability in the context of these social or relational attributes of children's integrity can facilitate or challenge students learning to nurse children.

Recent research in specialised fields like psychology and psychiatry is increasing the theoretical understandings of the parent-child unit. This concept has also become the focus of the evolving field of infant mental health. Nursing scholars and practitioners too recognise the importance of family to the child’s integrity. Recent nursing research provides insights like: involving parents in the care of their premature and critically ill premature infants is crucial for parent-infant bonding and as important as any other intervention (Benner, Hooper-Kyriakidis and Stannard, 1999: 328). Anxiety in children undergoing venepuncture is directly related to the anxiety shown by parents (Rodin, 1988:64). Parental participation in the care of ill children is theoretically well described by Coyne (1995 and 1996), but often reluctantly implemented, not only in South African settings but further afield.
Evidence in the present study of student nurses difficulty of working with a child whose mother is present adds to the understanding of this phenomenon and is further discussed in the section others present.

In addition to these three aspects of identifying a child’s integrity there are two more which are a direct outcome of injury or disease for a child namely, bodily impairment and disfigurement and the experience of pain. The emic approach gives credence to the experience of vulnerability by children which cannot be underestimated. A relatively insignificant intervention for a practitioner like giving an injection or inserting of an IV line can severely affect the child’s experience of bodily integrity. While insignificant compared to the invasion and scarring of surgery and the anguish and disfigurement suffered after having been burned, these experiences cannot easily be qualified or understood. The most we can do is attempt to understand, and it seems that the fact that students are novices places them in the position to do this more readily. It is evident that impaired mobility can cause a child great distress. This immobility can be as temporary as that caused by being restrained for an investigation or being placed at bed-rest; further restraint by a cast or urinary catheter certainly affects the child’s experience of himself and his integrity. Interestingly, students more often notice these aspects of vulnerability as newcomers to the setting than do those who work there regularly. The following data piece indicates several of the threats to a baby’s and his mother’s integrity as well as a doctor and a student’s experience of these. This piece also indicates the student in relay with the mother.

I noticed a mother standing in the passageway crying. ... no-one seemed to notice her. ...She said that the doctors had taken her baby away to the treatment room to take “blood from his bone”. I then realised that it was her baby that was screaming in the treatment room and this was obviously very upsetting for her. So I went to the treatment room and saw that they were taking arterial blood from the baby...I assured her ... as soon as they were finished, I picked the baby up. The doctor looked up and said “where are you going”. I explained to her that the baby’s mother had heard the screams and was very upset so I wanted to take her baby back to her - the doctor looked at me as if I was crazy but didn’t say anything else! The mother was relieved to have her baby back... After talking to her for a while I discovered that her baby had just been diagnosed with I.T.P* and she was still feeling very shocked and shaken by the news. She was not quite sure what the diagnosis meant but presumed that it was ‘serious’ because so many tests were being done.

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Pain and our perceptions, or misconceptions of how children experience pain can again be traced to positivist research that gave rise to general or meta-theories. Eiser (1990) cites two such theories which hold children feel less pain than adults do, because their nervous system is not yet fully myelinated and that babies feel no pain as they have no memory. Subsequent research and everyday evidence have refuted both these theories, yet they continue to influence hospital practice powerfully (Alderson, 1993:58). Despite prolific work by nurses in the area of pain recognition and management in children (Wong, 1995:1081), data in this present study show no evidence of consistent pain control in any of the settings where students worked with children. Students are often called upon to assist with dressings or painful investigations and again see and vividly describe the child’s vulnerability in this regard.

The presence of challenge as an attribute of a child’s vulnerability

Challenge, a perceived force which requires a response (Phillips, 1992), is a normal experience of growing up for children. On a continuum, however, challenge can range from the exciting triggers that elicit enjoyment and learning, to the opposite side of the scale where tragedy brings a challenge so great that it becomes threat. For children everyday living brings the excitement of the new and unfamiliar, ideally experienced growing up in the safe place of nurturing and sufficiency in the care of a family. Nurses, and by implication students, however, mostly encounter children facing additional challenges, often not in this safe place, but in a hospital, or another institution or public care setting.

The emotional challenges of hospitalisation have been well documented. In a review of this research Donna Mead (1989) reports that early research focused on the effects on the child of separation from the mother, citing Bowlby (1953) and Robertson (1956). She notes that later researchers concentrated on the child in hospital and notes the work of Mahaffy (1965) and Brian & MacKay (1968). Research findings indicated not only the need for emotional support and continuity but also that children understand and need to have information (Kluzing and Kluzing 1977, cited in Mead 1989: 61). It is, however, often difficult to disentangle the effects of being hospitalised and away from the safety of home from the effects of the illness and the treatment (Wolf, 1969: 53).
These perspectives add to the discussion of the challenge and the complicating effects of chronic illness.

A poignant phenomenological exploration of a child’s experience of asthma describes the challenge like this.

A child with asthma must dwell in conflicting realities; after all, until events are out of hand there is no classic look of sickness. The episodic nature of asthma and the triggering mechanisms of everyday occurrences feed the constant doubt... if the child dwells in the world of sickness he or she may be considered neurotic. If the child dwells in the world of health, then the existing rules and mores will soon find him or her ‘whimpy’ and deficient in stamina.” (Clarke:1992:133)

Clarke’s study also offers an alternative perspective of the hospital for a child challenged by chronic illness. The theme of hospital as liberation brings the perspective that hospital can ‘be a haven, a place of diversions, a place of safety.” (1992:134). Hospital is described as a place where the routine treatments follow predictable patterns: access to the nebulizer means that fear can subside. In an different arena of safety, the child knowing “I was gonna get better,” describes fear giving way to play (riding in the wheelchair) and pleasure (I loved that) (1992:134). Similarly, children, like many students described in the present study, whose homes or relationships are not safe arenas, may find some solace and freedom from fear in the hospital or institution. These children may temporarily substitute the threat of hospitalisation with reprieve and their experience of the challenge therefore changes their experience of vulnerability. Children who exhibit this kind of adaptation are often those whom students in this study engaged by befriending in playful connection. Students recognise these children’s resources and come alongside them rather than having to take responsibility for the threat the children face.

The temporary nature of this institutional reprieve must, however, be stressed. Children’s amazingly adaptive abilities often create the false impression that they are well in a long term care setting, but Roberts’ (1996) warning about good enough parenting by biological parents must again be sounded clearly. This is not only to keep child care professionals and students rigorously attuned to the importance of re-establishing but also to keep nurturing parent-child relationships. In this regard, the student mode of interaction termed in-relay-with the mother, in which students can be mentored, is significant.
It is also an appropriate mode of learning alongside an expert nurse practitioner working in the more advance-practice role. This is so well described by Burns (1993), as “creating a safe passage” in-partnership-with the child’s family.

Kendrick and Taylor (2000) contribute to the re-evaluation of hospitals and institutions as safe places in their re-exploration of the term abuse. They propose that not only does physical and sexual abuse occur in hospitals, but also programme and system abuse. These concepts add to the discussion of challenge in vulnerability by introducing the practices of over-medicating, inappropriate isolation, mechanical restraint and disciplinary techniques to our consideration of how children experience hospitalisation. The lack of understanding of children’s special needs and carers’ unrealistic expectations of children, their developmental needs and poor practice in pain control could lead to abuse. System abuse is more difficult to define but shortage of resources are likely to compromise ‘best care’ and this is certainly a well described feature of hospitalisation in South Africa and other developing countries. Insufficient staffing, both nurses and support staff, result in situations like the one this student encountered:

How these babies get through the day without their parents is amazing. Many of them often don’t even see their parents for weeks on end and I can only imagine that all of them have developed some way of surviving, some way of coping without their parents. I believe that hospitalised babies, irrespective of the coping method they use, must feel extremely lonely. In a ward with 26 patients, +/- 4-5 nurses and a strict routine, many of them just spend the day sitting in their cots attempting to raise their heads, sit upright or stand against the cot side. The ‘moments’ of attention they get (ie a smile, a few kind words or some physical contact) only creates a desire for more and the feelings they are left with when the attention is discontinued must be more profound than when a favourite toy is taken away.

The capacity for action as an attribute of a child’s vulnerability

This attribute, capacity for action, refers to the child’s ability to withstand, integrate and cope with the challenge. In contrast to terms like strengths, assets and functional ability; ‘capacity for action’ draws on the child’s resources, strengths and assets, it is the ability utilised by the child rather than an imposed or measurable standard (Spiers, 2000:719). Resilience is such a capacity for action. This is the well known and encouraging capacity that children and their parents exhibit in the face of extreme adversity. The work of at least one Cape Town based researcher portrays this capacity for resilience amongst children living in informal settlements in the most tumultuous times of apartheid in peri-urban Cape Town (Reynolds, 1980).
As can be expected, the data in this study are also full of expressions of students’ amazement at how children cope with the adversity of illness and circumstance. One example of a five year old with end stage liver failure and severe respiratory distress will suffice. The student met him on her first day in the intensive care unit, and she nurses him by befriending him in *playful connection*.

> While I was still looking at him wondering what was wrong with him, he called me to come to him. I looked around wondering if he really (*meant*) me, because after all I was a total stranger to him. I went over to him and his exact words to me were. “Hello, are you going to wash me, cause I want you to” From that moment on I fell ‘in love’ with him. I mean, here this child was half out of breath wanting to know if I, a total stranger, would wash him...he was most impressed with the mouth care I gave him.... There was a time when Dan was not on a ventilator and during this time I enjoyed speaking to him. Unfortunately when he could not go without artificial respiration anymore it meant that we would have to find some other means of communicating. We soon overcame that problem. I remember one specific incident when he mouthed the words “Are you going to do my mouth-care?”.

It was terrible seeing Dan on a ventilator because I knew how much he hated lying down flat on his back.... I will always remember Dan as the boy with big eyes, long lashes and a cute smile. But most important of all, I will always remember him as the boy who could not and would not give up, after all, in his words: “I’m going to play soccer like my brother, Clint one day when I’m big!”

Richter’s (1997) contribution to this discussion, especially in a third world setting, is that the effects of poverty and membership of a caste-like community pose the most severe risks to children. However, despite long-standing hardships and stressful life events, many parents living in wretched conditions manage to protect their children and render them, if not invulnerable, then at least resilient in the face of severe adversity (1997: 101).

The presence of multidimensionality as an attribute of a child’s vulnerability

Multidimensionality is similar to the previous attribute in that vulnerability has many dimensions and can vary from one child or parent or family to another. It may even vary from one sibling to another in the same family. An example of this may clarify the point. A child may be living in one of the informal settlements* around Cape Town. If his home catches fire, he may experience the multiple injuries of burns, a fractured limb and the emotional trauma of the experience. There may be simultaneous loss of all the family’s belongings and the cumulative effect of this on an already impoverished family.

The significance of this situation, not unusual in the experiences of children nursed by
students in this study, lies not in estimating the total level of vulnerability but in identifying what aspects of integrity are challenged. This emic approach to vulnerability that considers how vulnerability is perceived, certainly has significant benefit for understanding how students learn to nurse children.

The last two attributes of emic vulnerability - **power and mutual vulnerability**, are related both to children and those who care for them and include the experience of those learning to nurse.

**The presence of power as an attribute of a child’s vulnerability**

Power is an attribute of vulnerability which is so integral to this discussion that addressing it as the fifth aspect could be seen as negligent of the author. Power in the emic understanding is the extent to which a challenge directs or constrains action. In relation to this study, therefore, power is the extent to which the person - child or parent - perceives their potential for change and their ability to bring it about. Power is particularly important in the interpersonal relationships in situations of vulnerability (Spiers, 2000:719). Uneven power relationships are inherent in the ‘us-them’ relationships so prevalent in the social perceptions of children. They are seen as smaller, weaker, unable to fend for themselves while they are ‘becoming’: more competent, more mature, more able. In this situation others are typically able to exert power. So despite the fact that a constitution may give “...paramount importance to a child’s best interests in every matter concerning them” (The constitution of the Republic of South Africa, Act 108. of 1996 sec 28), there is significant variation in how power is exerted over children in private and public care settings.

A very brief introduction to the human rights movement, will introduce this part of the discussion about power. As power is often wielded in interpersonal relationships, an exploration of the nature of carer roles, in both formal and kinship relationships will follow. Power in the emic perspective is considered from the person’s experience: their perceived ability to bring about change. This requires that the nature of caring as women’s work be considered. The discussion is concluded with the child and mother’s perspective of power.
The student perspective of power and how it affects their interactions with mothers and children as evidenced in this study will be woven through the discussion.

Children’s human rights

“The care and protection of children is a practice and ethic deep rooted in the wisdom and culture of all societies” (Grant, UNICEF quoted by Reynolds, 1999:605). As Reynolds explores the challenge of child rights to health professionals in South Africa, speaks of the “deep and universal - but often neglected - knowledge that children are vulnerable” (1999:605). The human rights movement is the modern societal response to issues of power and abuse in the last 400 years. Reynolds (2000) describes how the movement was originally aimed at establishing autonomy, self-determination and non-interference initially for nobles and priests – the Magna Carta in 1215. A recognition of the rights of women and children was not to follow until much more recently. The United Nations adopted the Convention on The Rights of the Child in 1984. The convention embodies the rights of the child to resources and protection from harm, extending the meaning of ‘rights’ from the original non-interference to active interference on the child’s behalf (Alderson, 1993:31). As Reynolds explores the history of children’s rights, he maintains that their situation is closely linked to poverty, but more closely linked to social inequality than general economic hardship (1999:605). Although the Cleveland report of 1987 was praised for recognising the “child as a person”, it did not recognise their ambiguous status in society (Kessel, 1989: 347). Kessel also contends that child abuse is endemic rather “than a series of aberrant actions by pathological individuals”. The protection afforded children in the societal or legal realm is not easy to establish or police in the private realm of interpersonal relationships in the home, where children often continue to bear the brunt of power struggles.

The nature power in carer roles

Many of these power issues arise in the interpersonal context of caring. The care of children usually comes informally from family or neighbours, but child-care is more frequently becoming formally packaged by institutions like schools and hospitals, with trained personnel. Maslach argues that “…intrinsic moral and human values can be overwhelmed by a particular ‘care taking’ process”. She proposes that exerting power over those less powerful is not caused, as often as postulated, by burnout (1983:x).
Maslach raises the possibility that our meanings are construed by our own socialisation and raises the question about whether “care-giving is more likely to be shaped by an intrinsic desire to care compassionately or the negative demands of the situation”. Haegert contributes further by suggesting that in the negative socio-cultural economic demands of some situations of caring, carers could “lose their ethical-selves” (1999:13). These insights broaden the widely held view that the non-caring or distance in caregiving is associated only with depleted resources in mothers and carers. As they explore the nature of nursing in this study, students recognise both these possibilities. This excerpt indicates a student’s sense of power.

It is infuriating how task oriented these nurses are and it is pointless trying to change their mindset because they have worked like that for years. Perhaps things will be different when I am qualified and will have the hierarchical standing to make some changes but right now the hospital system really depresses me.

P3.1 journal doc. 40-45

Power in formal carer roles
People “…charged with the care of children separate from their families undertake parental responsibilities for them and are therefore accountable for the manner in which they discharge these parental duties” (Roberts, 1996:100). This could by implication, mean that in a carer role, ‘you treat children as you would your own’ therefore in ways congruent with your own socialisation. This may sanction exerting power over a child. In this study’s clinical settings, students are learning alongside nurses who are being guided by their own socialisation as well as negative socio-cultural and economic demands, rather than by the ethical norms and values of theory-based nursing. Students express their distress at having to learn in these settings, but are also not immune to the traps held by their own socialisation and difficult work circumstances. Evidence of the choice not to engage a child in the mode called distant doing may be seen as a way of managing the situation and themselves. Students require a legitimate space in which these ‘costs of caring work’ with children can be counted. Students describe that this ‘care-taker’ role requires courage. It is a role other than a more familiar ‘kinship’ role. In it they find themselves often having to care, rather than choosing to care. This courage to care is sometimes a quality hard to learn, yet without which “there is a possibility that the ideal of care will become a caricature of the real thing” (Haegert 1999:12).

I have realized the importance of courage, humility and risk taking in nursing. Engaging with children somehow, for me requires greater risk taking than engaging with adults.

P3.1 1225-1226
Power in kinship caring roles

Other authors confirm that in this interpersonal context of caring for children, the challenges and threats are hard to quantify. Mothers report that it is hard to be nurturant, patient and involved with an infant or young child when feeling depressed or demoralised (Richter, 1997:1000).

It is not unusual for carers, in the absence of these resources and in this kind of emotional space to exert power over children, especially if their own socialisation and experience permits this.

A further consideration in this discussion is how the perception of power or the lack of power affects the vulnerability of mothers and nurses in their caring work with children.

Power in caring as women’s work

The discourse of caring, by implication mothering and nursing work, has been engaged in the last two decades. The most prominent nursing scholars, researchers and practitioners have been from the emancipatory paradigm, including critical and feminist theorists and those who have used phenomenological goals of making the hidden visible (Benner, 1984; Watson, 1985; Leininger, 1988). Boykin and Schoenhofer (1990) have traced the scholarly contribution various authors have made to conceptualising nursing as a caring practice. They have identified the five dimensions of caring as the ontological, anthropological/ cultural, ontical, epistemological and pedagogical dimensions.

Traditionally caring for the weak and the sick is work designated as ‘women’s work’. It includes rearing and educating children and it is sometimes called ‘invisible work’ as it seems to happen regardless of societies, plans and policies. This type of work is largely ignored and is accorded little value in the dominant culture of many societies. Mothering and nursing, are sometimes called nurturing and although this is a familiar term, like the term noble it evokes a sentimental, maybe romantic picture of rather mindless tasks. Witbeck (1983), however, contends that the “creativity and responsibility of all parties in the conduct of the practice of nursing in its full and liberated form is inconsistent with the sentimental picture of women’s self-sacrifice” (cited by Benner and Wrubel, 1989:367).
As has already been said, cultural meanings, socialisation and current circumstances shape care giving. Nurses are the ones most often confronted with societal failure - the breakdown in caring that is evidenced in violence, abuse and the loss of self care (Benner and Wrubel, 1989:367). As numerous data have already shown in this study, students often encounter children who had experienced a breakdown in caring. Much of their puzzling out connection with these children indicates the creativity and strong sense of responsibility ascribed to nursing, quoted earlier by Witbeck.

Altruism and autonomy are seen as opposites in this view and as altruism is the assumed duty of the carer autonomy is not offered or expected. The loss or lack of autonomy is a risky place to be, with the possibility of power being wielded and it gives rise to a situation which further increases the experience of vulnerability of the carer and by implication, the child. Within the more emancipatory perspectives (Gilligan 1982), and certainly within a traditional African perspective, persons are seen as related to others and concern for others is not necessarily competitive with self-interest. Gilligan (1982), in re-defining Kohlberg's scheme of moral development, contends that a personal caring morality is not inferior but complimentary to Kohlberg's level six of abstract principles. "Caring for others contributes to a world where one can care and expect to be cared for..." (Benner and Wrubel, 1989:367). Although Gilligan's insights have "...been welcomed for recognising the mature morality of many women (and also many children) and granting them more moral status..." (Alderson, 1993: 63), these theoretical understandings are still far from women's every day experience.

This dilemma of women and children's lack of status or voice in many clinical settings is one that students in this study often describe. As they stand up for children and mothers in situations which they perceive as unfair, they often receive ridicule. Their caring practices thus increase their vulnerability. In these situations they sometimes persist, sometimes giving more than they feel they are able in the mode of connecting termed dutiful safeguarding. In this mode of connecting with children, they were also seen placing themselves between the mother or the child and other caregivers, acting sometimes as a barrier and sometimes as a bridge. Both these stances are an attempt to deflect the vulnerability they perceive as resulting from power struggles.
When being the barrier their actions can be described as altruistic in that their attempts to safeguard were duty determined and sometimes at some cost to themselves or their resources.

I spent quite a lot of time today with a small baby who is dying of AIDS. The baby weighs 2.5kg and is 4 mths old. She is covered in open sores and has oral candidiasis all over her mouth. I have been giving her every feed... Each bottle of 40mls takes about 15minutes for her to drink, so I always get comments that I am spending too much time with one child ....[O]ne (nurse) said to me that I am spoiling the children and when there is no ‘work’ to do then I must relax. I was furious... not angry because they were criticising me but because of their attitude towards their work.

For me my work is the children. Anyway, despite the ‘advice’ from my fellow nurses I decided to spend as much time as possible with the children and to do anything that I could to bring (them) some comfort and love... I was completely drained at the end of the day but I did have a feeling of accomplishment because I made a real effort to interact with each of the children. THE NEXT DAY... I was still feeling exhausted from yesterday...

Acting as a bridge is more likely to occur in the setting of interpreting the experience for the mother. The bridging actions of the students are often observed in their mode of being in relay with the child’s mother; sometimes they are interpreting for a child’s mother by offering additional information and at others times merely positioning themselves as a support or buffer. Ethics of care and responsibility in these settings are interestingly complimentary. The caring these students display is different from the strict ethic of rights and justice. Findings of this study certainly bear witness to Benner and Wrubel’s assertion that caring and interdependence are goals of adult development (1989: 368). This is a view more akin to African communalism than what these authors call the damaging cultural myth that views autonomy as the hallmark of maturity. For these students it was also quite clear that caring and being cared for promote their personal health. This concurs with Heidegger’s (1962) statement that caring is the most basic human way of being in the world. One student who meets a mother and her baby on their re-admission for diarrhoea displays this bridging care. The baby was hypernatremic after the mother had mistakenly used only a quarter of the required amount of water to make an oral re-hydration solution

The reason for this is that she understood it this way, she really thought this is the way she was taught it should be done...The nurse who taught this mother was very upset and started shouting ...that this baby can fit at any point... This turned out to be a double shock for me. The mother was crying possibly feeling guilty, frightened by the consequences and the fact that the nurse was angry at her. Fortunately, the nurse left the room immediately. I reassured the mother that I understand it was a mistake.
The important thing is that we were going to do the best of what we can. ...I had so much empathy and (com)passion for the child. I was also anxious since I did not know what was gonna to happen to the child. ...[B]ut I (made myself available) to the mother when she needs anything or wants to ask questions. P4.17 Narrative

Even though the mode of connecting called in relay with the child’s mother can be seen as the most adaptive or 'best' way of connecting with children and their mothers, students who sometimes engage in this way did not do it consistently with each encounter. One may understand this in several ways. Students mustered their courage and cared wholeheartedly for some children and their mothers. In these relationships they recognise the “privileged place of nursing” (Benner and Wrubel, 1989:xi) but also how often the burden of caring - either their own or the mother’s - is undervalued. While puzzling out connection and grappling with the difficult question of their own value and worth, they may choose to engage differently with another or even all other children. It is evident that the consequences of their engaging a child are that their own resources are either depleted or restored by caring. There is, however, no evidence that the stress of engaging with vulnerability disappears as they learn to ‘cope’ in different ways with divisive power issues. Students journals reflect an ongoing dialogue of exhilaration in the triumph of really engaging a child within the reality of this ‘invisible women’s work’ they are learning.

Mutual vulnerability as an attribute of a child’s vulnerability

As has become evident, the nature of the interpersonal relationships in which the caring of children happens makes this, too, a significant attribute. The emic view of vulnerability includes the notion that both the nurse and the child are vulnerable in the interaction. The status of the caregiver is intimately related to the status of the ones cared for. Nurses who care for children, or others who are culturally devalued by their invisibility, experience not only the inequality of their lower societal status (Benner and Wrubel, 1989:368), but by the nature of the relationships, greater vulnerability. The implications of this for the learning process and experience of students learning to nurse children, have been woven into the above discussion. The central conclusion in this attempt to understand how students learn, namely that they puzzle how to connect and therefore engage with children, is most significant. Engaging brings reciprocity and in choosing how to ‘be with’ children students experienced various aspects of these children’s vulnerability.
A child’s scarred integrity or additional challenge often moves students to find their own capacity for action. Recognition of a child’s courage or resilience often helps heal some of a student’s own scars. Seeing that some children are suffering and not going to recover rapidly helps them to muster patience or courage for the next challenge.

Learning in this context with real, vulnerable children has offered the researcher some clues for understanding how students respond to the emotional risks of caring. The central conditions of how students perceive their resources, work with their very real sense of responsibility and what they know as well as the significance of those present in their encounter, are all ways in which they process and make sense of their experience. Spiers (2000: 720) concludes that vulnerability is a dimension of quality of life. This is a good description of how students learning about children experience their own and children’s vulnerability. While the risk implies potential harm, vulnerability is also part of their experience of growth in their encounters with children. In Beck’s study the conditions that arose as central to students’ caring behaviour with exceptional children were that they experienced a bolstered esteem and an unanticipated self-transformation in the reciprocal sharing of care (Beck, 1992:364). In the present study, too, there is evidence of these two consequences of puzzling out connection with children: reciprocity in engaging and transformed perceptions.

In describing the care of a nineteen-year-old girl with a severe, traumatic head injury, Margaret Fenton eloquently describes the risk of engaging:

I am so afraid ... of the responsibility... of being your nurse ... and of being touched by the fragile thread that is your hold on life ...

(in Benner and Wrubel, 1989: 377)

This extract portrays how the threat inherent in being repeatedly confronted with one’s own vulnerability, violence and the threat of pain and disfigurement does not produce immunity. “The threat seeps through” (Benner and Wrubel, 1989:377). Research indicates that nursing children is the most stressful of all the rotations in the nursing curriculum (Oermann and Standfest, 1997).
This broadened understanding of vulnerability - the child's and the student's - assists us in understanding this more clearly. It is evident from this study that for students, learning to nurse must offer opportunities to experience that nursing is intimate and particular. It must also help them with "...the very difficult knowing that there is no way to guarantee the success of caring" with each child they encounter (Benner and Wrubel, 1989:385). Learning in this way does, however, help students to learn the ethic of relatedness and that mutual trust is required when caring for the incapacitated.
Section 3: Students as adolescents

The students themselves have been found to embody the very context of this process of learning to nurse children. Glasper and Ireland (1988) have used the British society of Paediatric Nurses' current motto that "it takes a special kind of nurse" to argue that students in this field are "a special kind of learner".

The complexity of caring work with children is often undermined by the myth that babies and children require only rudimentary care. This is rooted in the women’s work perspective, which still pervades child care facilities in South Africa.

The students in this study were all enrolled for tertiary study in a Bachelor degree, directly after leaving secondary (high) school and most were eighteen years old. This age group of young people can easily become 'invisible' as they are considered adults by some and children by other societal institutions and policies. Jenkinson (1997: 58) maintains that "despite the constant flow of young secondary school leavers into the nursing profession in the United Kingdom, comparatively little consideration has been given to the effects of adolescence on the individual and his or her subsequent ability to care for or to meet the needs of others." The dilemma of definition of this age group has been partly solved by the WHO’s introduction of “adolescence and youth” to describe the age group between 14 and 20 (Proudlock, 2000:26). Although various theorists like Piaget and Erikson have attempted to explain adolescence as a life stage, there is no evidence to support the view that it is a universal or normative crisis. The students in this study and discussion are described as adolescent to explore this life stage as a condition influencing how they learn to nurse children.

A discussion of students as adolescents also needs to include both emic and etic perspectives. The theories as well as the experience of adolescents must be considered in the context of their life experience and the shifts in current thinking (described at the beginning of this chapter).
Many South African young people, certainly all the students in this study, have entered a
global subculture opened up for them by the technology of satellite communication. Like
adolescents in other developed countries, they are grappling with the complexities of the
emerging twenty-first century. Their views and experiences are shaped by the paradoxes
posed by the media and technology, which welcome them as global citizens. The
paradoxes of war and peace, famine and plenty, materialism and idealism, democracy
and dictatorship, higher education and unemployment and isolation and caring have
become their reality and their context for developing identity. These are juxtaposed with
the values, culture and memories of their families and communities who are still mostly
tentative about the changes unfolding in the new South African democracy.

The nature of ‘adolescence’ as context for students’ learning is often characterised
by their expression of ‘wanting to give of themselves’. Magen (1983:107) reported that
adolescents who “reported positive experiences of high intensity more frequently
showed a readiness to be committed beyond themselves”. Their enthusiasm and energy
are probably the most invigorating aspects of working with young people in this age
group. The stress and intensity of learning to nurse children can, however, temper this
energy. The vulnerability of “being touched by the threads of threat” that bear on the
children they work with is probably expressed, some may venture ‘exaggeratedly’, with
their characteristic energy. Students often temper these expressions of energy and
abundance as they express their need for choice. They are seen to moderate their own
involvement with children and learning with an awareness of ‘needing to be ready’. Both
this energy required for exploring and the need for choice are recognised features of
adolescence.

These features can better be understood by using developmental theorist Erik
Erikson’s scheme as a ‘tool’ rather than a “prescription to abide by”, following his own
advice (1950:243). He describes adolescence as a period of ‘storm and stress’ as the young
person transits from “…the learned morality of childhood to the ethics of adulthood”. It
can be a traumatic time as the individual searches for identity and simultaneously the
answers to questions like: “What must I live up to?”, “What are my obligations?” and “To
what (or whom) must I commit myself?” (Magen, 1983:97). Adolescence is characterised
by significant social role changes.
Leaving school and starting university for most of the students in this study also meant leaving home. They now found themselves in an entirely new subculture: one of peers, different from family, but often preferred by these young people. Students have to make choices which will affect the whole of their lives. The theoretical understandings of development, like Erikson's, have of course emanated from a Western perspective and place the self as a central concept to development of identity. Within an African perspective, a young person will develop identity by becoming part of the group, family and community. Initiation ceremonies, usually at puberty, but often delayed by circumstances, are about proving self-control and then being welcomed into the group, usually back into the family, in a new role. Peer group membership interestingly serves functions within both these perspectives of identity formation.

Membership and identification with a peer group serve as the context of much of the emic view of adolescence. A Canadian study used the ethno-nursing method, to identify themes about care and health from a group of adolescents (Rosenbaum and Carty, 1996). Firstly ‘care’ for these adolescents meant “being there”. This is a theme often seen in exploring nursing student/faculty caring (Beck, 1991; Johnson, 1992; Redmond & Sorrell, 1994; Cahill, 1996; Hanson & Smith, 1996). This aspect of presence has been identified as the essence in most of the scholarly explorations of caring, including in the initial work of Benner (1984) and expanded in her later writing with other scholars (Wrubel 1987 and Tanner & Chesla 1996). It is no different for young people. The condition termed others present, which emerged from analysis in this study, is related to the nearness of others. These students also value the authenticity of other’s presence. In Rosenbaum and Carty’s study, presence is measured by the young people in terms of “trustworthy listening” (1996: 743). Authenticity and honesty are recurring themes in other studies with student nurses. Beck conceptualised this as ‘authentic presencing’ in caring experiences between students and children (1994: 363). This central attribute valued by adolescents is certainly congruent with students in the present study and also with the practice and theoretical underpinnings of nursing.

Rosenbaum and Carty (1996:746) found strong evidence that young people emphasised intergenerational differences to establish identities separate from their parents.
This could complicate caring relationships for young people, but in nursing children it seemed to assist students in building a bridge between older nurses and children. The students identify with the children and often attempt to interpret their behaviour for staff and sometimes for parents. They can draw on their more recent knowing of the experience of childhood. In this study the process of learning to connect with children does seem to follow a pattern of identifying initially with the child to later identifying with the mother, as a fellow adult. Identifying with the child can lead to either befriending (in playful connecting) or to protecting the child whom nobody else seemed to understand (dutiful safeguarding). It is interesting to see that identifying with a very young or inexperienced mother also elicits one of these modes of interacting. But if the student identifies with the child’s mother as an adult, her relationship is most likely to be in relay with this mother. Another aspect of students’ identity can be related to the theme ‘confidences as care’ (Rosenbaum and Carty, 1996). Young people expressed the importance of their information being held in confidence and not retold. Participants in the present study also sometimes mentioned the importance of this, with staff on the ward and nursing faculty. It may be this that makes the peer group a safer setting than being with adults, family or nursing faculty.

Reciprocal care was a feature of adolescent meanings ascribed to care in the Canadian study (Rosenbaum and Carty, 1996). Johnson (1992:195) describes reciprocal or mutual relationships from a student perspective as different from the traditional teacher-learner relationship: “To know the students and to be known by them is a critical aspect...”. This is a recurrent theme in studies that explore student/faculty interaction. Students value reciprocity in relationships (Halldorsdottir, 1990; Hanson & Smith, 1996). In this study students also obviously value this aspect of relationship with the teacher and peers, in the clinical setting they worked more concertedly to establish themselves as resource to team.

‘Reciprocal sharing’ is a theme also evident in students’ caring experiences in caring for handicapped children (Beck, 1992: 363). In the present study, students experience the reciprocity of engaging with children as reward or satisfaction. As in the previous study (Beck, 1992), the reciprocity of relationships involved feeling secure in sharing themselves.
The meaning young people attribute to “reciprocal relationships as caring” is a feature of their development as they establish identity. Another important conclusion, confirmed in the present study, is that the experience of care is identified as the sustaining force of young people’s resilience (Rosenbaum and Carty, 1996:744).

These three aspects defined from Rosenbaum (1996) as characteristic of young people’s perceptions of care - presence, authenticity and reciprocal relationships, are also central to how caring has been conceptualised in nursing. These qualities have been observed in at least two studies of students caring with children, the present study and Beck’s (1992), and may be features of student nurse caring in other settings. I would like to contend that adolescents bring their naturally held values about caring and relationships into nursing. Their socialisation into nursing may then nurture these values or reconstruct them into what students often perceive as ‘more professional’ traditional caring behaviours. If we, as nurse educators were to recognise the aspects of caring that students value, we would change our approaches. Rather than holding the belief that we have to teach students new relational skills, we could concentrate on affirming their caring while we guide them to find their way in becoming nurses. Chater (1996) reported the value of facilitating relational and group skills in small groups in the UCT Nursing Department.

The other aspect of relevance to this study is the meanings adolescents ascribe to health. Rosenbaum and Carty (1996:744) found that for the young people in that study health included “…well being, being fit, absence of illness, dealing with problems and taking responsibility”. These perceptions are interesting to compare with those expressed by student nurses learning to care for children. Their theoretical understanding of the concept ‘health’ would have been influenced by participation in an obviously health-based curriculum for two years. Like the young people in Rosenbaum and Carty’s study, their understanding of health is more than the absence of illness. Students’ unforeseen illnesses disturbed them. Getting flu or diarrhoea always elicits evidence of trying to explain why they are ill. They spend time trying to find out which child they may have ‘caught it from’. They reassure themselves and the teacher about their rigorous hand washing or what they did or didn’t do to catch it.
Another feature of adolescent students in this study is that they vigorously grapple with problems - not only with those problems directly related to them, but also with issues of social justice or injustice described earlier in this discussion. This vigour may be related to what Erikson (1968) terms their emerging sense of identity and their transition to the ethics of adulthood. An inability to solve these problems results in high levels of frustration - a salient feature of student experience in this study. Students’ sense of responsibility may not be completely unrelated to these broader societal issues. It seems that they negotiate their levels of responsibility for the child or the solution of the problem or ill, in order to lessen its burden on them. Their emerging sense of choice and wanting to be able and allowed to make their own choices, adds to their burden of responsibility, especially when they decide they have no choice but to bear the burden.

As indicated in the findings, three students in the study were men. Although there was little about their process of learning that was obviously different, the central issue of their gender in a mainly feminine profession must be considered. A Canadian study which explored men’s experience of learning to nurse, found that their learning to care is shaped by their personal experiences, their expectations of others and their evolving understanding of ways of caring (Paterson, Tschikota, Crawford, Saydak, Venkatesh and Aronowitz, 1995). These are probably very similar to the shaping factors for women. Another study done in the USA found that although male students perceived nursing schools as supportive, men still report feelings of isolation and self doubt (Kelly, Shoemaker and Steel, 1996). The largely feminist perspectives related to learning to care, most notably the writings of Gilligan (1982) and Noddings (1988), could be seen to portray learning to care in an interactional context and as a female experience. Yet in the Paterson et al (1995: 600) study, men reported that they had “to be open’ to learning and that they made use of interactional strategies in learning. In this study this was certainly also evident. Male students, although touching and handling children less frequently, also set connecting with children as their central motivation.
Students who encounter children, often at their most vulnerable, are also probably at their most vulnerable as they approach these settings. This study has revealed that they, too, experience the threat to their integrity: an example of this is that they often experience the lack of support of the unit nursing team. Students may thus remain ambivalent about belonging to this team. Their experience of recurrent, often minor illnesses and feelings of stress about the weight of their responsibility is a threat to their integrity. The study reveals that their experience of challenge is not dissimilar to that experienced by children in hospital. The procedures, the unpredictable rhythms and the complex relationships with children, their parents and a host of experts and others more familiar with the setting than themselves, contributes to the hospital initially being a space of profound unfamiliarity.

Students continue to be uncertain about their ability to respond adequately to the unpredictable and unusual intensity of children’s needs. Their capacity for action and how it differs from one student to another is well described in this study. These ‘threats’ and the theoretical model suggested by Erikson (1968) also generates considerable thought regarding the suitability of some young people to meet the physical and emotional demands of nursing children. A critical level of self-awareness is required to undertake reflective practice, which is becoming a central feature of nurse education in the United Kingdom (Jenkinson, 1997), and further afield. Reflection is also a feature of learning in this study embedded in the UCT nursing programme. It is therefore important to consider the nature of students in this developmental stage. This is firstly, in relation to the complexity and nature of work with children, as a vulnerable group and secondly, to consider how appropriate or wise it is to expect reflective practice from learners this young. Various intellectual and affective activities required for this mode of learning “…involve a willingness of the individual to look back at an experience, reconstruct, re-enact and recapture the event. This includes re-visiting the emotions, feelings, thoughts, achievements (or failures), that were associated with the episode” (Jenkinson, 1997:59). The same author argues that this kind of analysis may lead to development, or learning, but may also prove to be an extremely stressful and painful process that according to Cell (1984 cited by Jenkinson, 1997: 59) could harm the individual’s self concept and actually limit their potential for growth.
Jenkinson also quotes Erikson (1968) as suggesting that adolescents require ‘space and time’ and opportunities to experiment and explore. If they therefore become engaged in activities designed to criticise and analyse not only their own, but also the actions of others, this may be less than helpful for their development and ultimately learning and nursing practice. Jenkinson (1997) concludes that in working with adolescent learners, teachers need to use reflection with caution and he emphasises the important role of mentors in clinical situations.

These are certainly valid considerations and are be confirmed by the experience of students in learning to nurse children. While some students choose not to reflect on their experiences, others choose to make sense of the experience by reflecting extensively. It is evident that not only nursing children, but also thinking about their own experiences, required courage. These are two sequential processes for these students and not often simultaneous. Doing and later reflecting, is different to the reflection used by expert nurses described as thinking-in-action or reasoning-in-transition by Benner et al (1999). Thinking about and doing are also not always linked. These students often did the one without the other. They also sometimes think about doing something, as was evident in their journals or conversations, but do not do it. The nature of this reflection could be called ‘reflecting-the-ought’ - thinking about how things ought to be, and is further explored in the following chapter. In this learning process there is also evidence of the differences between students ‘private caring’ - what they think and believe about caring for the child - and ‘public caring’ - what they do when in the actual and public situation of the ward setting. These two meanings of care are well described in a recent South African study by Haegert (1999) in which she saw that many registered nurses were not able to practise care in the way they described or in accordance with their intrinsic capacities and private meanings.

In the present study, the two aspects of the nature of students that emerge as key to the context of learning are, their awareness of their resources and their personal sentiment of ‘liking’ children. These two embody aspects of personal awareness and relational choice. The issues related to being in the developmental life-stage called adolescence are influential in the process of learning to nurse children, but in each situation with each child, they are tempered or exacerbated by the students’ perceived resources and choices.
Section 4: What students do as they learn to engage children

The vulnerability inherent in being a child and emerging into adulthood brings with it a real threat to personhood, both for students and children. “Nursing has long understood that restoration of personhood can only be gained in the context of person-to-person relationships” (Ryan, 1990:49).

What students do as they learn to nurse children has been traced through the discussion of current shifting perspectives, the nature of caring for children and the nature of students in the life stage of adolescence. The discussion of these levels of social interactions confirms the complexity of the process of these students’ learning to nurse children. This is now followed by discussion of the level at which the actions and interactions actually occur.

Travelbee’s (1966) relational model of nursing is one of the nursing theories in which this is evident. She claimed that the purpose of nursing is achieved through establishing human to human relationships (cited by Ryan, 1990: 50). But as Ryan (1990:50) points out “[i]t is difficult to practise nursing as if people matter”. This statement invites recognition because although children did ‘matter’ to many of the students in this study, connecting with them was mostly hard work. Peta Bowden contends that “[c]aring expresses ethically significant ways in which we matter to each other, that this transforms interpersonal relatedness into something beyond ontological necessity or brute survival” (1997:1). In exploring the ethical importance of caring, this ethicist notes the variety of relationships in which caring is practised. Her investigation explores four of the relationships in which caring happens: mothering, friendship, nursing and citizenship. Data in the present study often indicate how students attempt to make sense of the relationships they are forging with the children by comparison with types of relationships more familiar to them. I contend that students learn the unfamiliar third kind of relationship, nursing, by trying to find a ‘fit’ from portions of the more familiar first and second, mothering and friendship.
This part of the discussion briefly explores Bowden’s perception of relationships in nursing and then looks at the modes of interacting that students choose as they puzzle out a connection:

- distant doing
- dutiful safeguarding
- in relationship with the mother
- playful connecting

Relationships of nursing care are formed between people whose connection with one another is primarily governed by the responsibility of one person to respond to and serve the needs of another (Bowden, 1997:102). This definition is borne out in the present study in which the children are always strangers, not related to the students by ties of kinship or friendship. Bowden explains that nursing is thus "... directly subjected to determinants of publicly administered norms and structured by publicly sanctioned conduct" (1997:102). Studies which examine the nature of socialisation of nursing students consider how this publicly sanctioned behaviour is acquired and shaped. The present study, however, describes the particular aspect of learning the person-to-person relationships in which nursing children occurs.

In the life stage of adolescence many of students’ familiar relationships are characterised by choice and personal freedom. The contrast of relationships characterised by public regulation and responsibility brings an added dimension to what learning to nurse must encompass. Throughout the present study, students are seen translating their ‘private’ knowledge of relating to children to the ‘public’ domain of nursing children. Students often puzzle the difference between mother’s work and nurse work, often not liking what they see of either and so they try to work out a mode that suits them better. Working out what to do is then done in this context of encounter with each child.
**Distant doing:** is the mode of connecting that is characterised by apparently not interacting with the child. This mode of interacting was often related to getting the task done only and was initially seen as not connecting and therefore an apparently ‘negative’ mode of connecting. It can also, however, be understood in terms of the complexity of what the student perceives must ‘be done’. Amy Rossiter, a sociologist who explored early mothering, describes the tasks as “consuming”. She contends that “…in the details of soothing, feeding, stimulating, changing, amusing, lulling we see the intensity of the infant’s vulnerability to her mother and the remarkable extension of the mothers awareness to the continuous inclusion of the baby’s needs” (in Bowden, 1997: 50). As the student sees the vulnerability and needs of the child and works out what must be done to meet these, she may choose this mode of distant doing, though often not consciously. Lulling, feeding or changing are seen in this type of interaction and are a response to the child, but have a different purpose, getting done. So stopping the crying has to happen in order to get to the next baby or child – to get done.

This option of interacting is also ascribed to the student’s available resources. Rossiter suggests that there are relational conflicts created between the needs of the child and those of the mother (or care-giver) and that this is often seen to be resolved by the mother’s self sacrifice (Bowden, 1997: 58). It is evident that the student, too, experiences relational conflict in distant doing as she perceives this that caring for the baby also requires this self-sacrifice from her. This is not an easy option for the student especially not in this context of needing to care for a ‘stranger’, or as in the context of this study, many little strangers. Distant doing is therefore the choice of interaction directed to get done rather than to engage or understand the child.

**Dutiful safeguarding** is a mode of connecting in which the student does display a level of self-sacrifice. The student’s sense of responsibility is particularly evident in this mode. She often perceives others as not taking responsibility for the child and will assume the responsibility for all the child’s needs, often without reckoning her own resources. This mode of connecting initially emerges as ‘mothering’, for two reasons. Firstly, peers describe a fellow-students’ interaction with a particular child as mothering, often with admiration. In comparison they see themselves as unable to care in this manner.
Secondly, it is evidenced by protective behaviour as well as ‘teaching’ or instructing in older children. Sarah Ruddick (1980), a philosopher whose landmark work on the concept of ‘maternal thinking’ says “To be a mother is to take upon oneself the responsibility of child care, making its work a regular and substantial part of ones working life” (in Bowden, 1997:25). The mode of dutiful safeguarding is often chosen in the absence of the mother and therefore the obligations to the child seem more obvious. In response to the question: “So what do you do if the mother is not there?” this student answers:

- Nurturing, TLC*, stimulating, doing what the parent should be doing, maybe you try to give them a little bit more than the kids whose mother’s are there. You are always there checking if they have what they need, checking if you can do anything for him....we know whose parents are there. There is ‘no visiting time’ in hospital. The mother is either there or not there. 

Bowden maintains that the perception that mothering means the adoption of these obligations for the well being of a child may be “…a convenient and instrumental understanding of the specific activities of mothering” (197:25), but in the present study they were useful in understanding students’ responses. Ruddick held that mothers’ actions were in response to various demands: firstly, from the child - and these are twofold, for preservation of life and for fostered growth. These are the two ‘demands’ recognised in student action. The first is particularly evident in a hospital setting and students often express their fear of this demand. The overwhelming responsibility for the preservation of a child’s life is often difficult for them to carry. In this setting it often overrides the demand for fostered development, which was seen in how often students in this mode of dutiful safeguarding tend to protect a child conscientiously ‘just in case they get hurt’. Ruddicks’ second demand is the socio-political imperative on mothers, which she describes as what others expect regarding how a child should be raised: in manner acceptable to the group (in Bowden, 1997:25). Although this is not something students experience consciously, the social demands of relating to the child in the publicly sanctioned norms of nursing the child are often compared with the more familiar norms of mothering the child.
Students' experiences of connecting with a child as “a continual response to the child’s demand for protection and preservation [and] a passionate work of securing safety of the extremely vulnerable child, within the largely uncontrollable and dangerous environment”, are comparable with Ruddick’s description of mother’s work (in Bowden, 1997:26). Rossiter’s understanding of how mothers of newborn infants learn is similar to that seen among students. She says that it is ‘shaped by uncertainty about the explicit requirements of the relationship...[and] that it relies on trial and error learning with [all] its anxieties ...and is played out in a state of exhaustion” (Bowden, 1997:50). This type of learning, anxiety and fatigue are all features of students’ experience as they puzzle connection in these two modes of interacting, distant doing and dutiful safeguarding.

The comparison of student experiences with those described in mothering serves to explicate the relational conflicts students encounter as well as some of the ways in which they compare familiar with unfamiliar and new relationships. Bowden’s exploration of caring in friendships and nursing adds to the above discussion of mothering as the next two modes of puzzling out connection are considered.

As students work out the relationship of being in relay with the child’s mother, they recognise, to some degree, the nature of the mothering. One student introduces her narrative with the statement that “the together of child and mother are the story of my relationship with the child”. This student sees the mother’s relationship as the child’s primary relationship. In this study this usually meant that the mother carries the responsibility for the child. The student realises that in this the mother requires her support and this often includes information about the child.

In this mode of interacting, students are moving towards what they perceive to be nursing relationships. They recognise and sometimes expect that the mother will maintain the required balance in caring for and relationship with the child in the face of the difficulties of illness. Ruddick observed that mothers “...maintain balance through holding a relational stance to another that minimises risks and reconciles differences rather than accentuate them” (in Bowden, 1997:50). It is not sure whether students who use this mode of interaction recognise this in mothers or merely expect it of them.
Even if they do recognise the ambivalence that Ruddick describes as a “central theme of mothering”, they are unlikely to engage this ambivalence of the mothering relationship. Closer relationship puts the student at greater risk of being engaged by the mother and only few students will place themselves in this position knowingly. Unlike the experienced child nurse described by Burns (1993) as creating a safe passage for parents and children in hospital settings, students may facilitate, but do not create this passage.

*Playful connection*, the other mode of interaction which students use, is akin to the relationship of caring in friendship. Bowden describes this type of relationship as characterised by informality and relative absence of controlling institutions and conventions. She describes these relations as being “… exhilaratingly free from regulations and profoundly fragile” (Bowden, 1997:60). Like in friendships, students choose the child with whom they relate in this way, which is probably their most familiar and natural mode of connecting. It often happens with a child to whom the student can talk. Story telling and conversations offer the opportunity to “…elaborate observations and establish continuity and connection” (Bowden, 1997:29).

Another feature of this mode of relating to children is that of trust. Trust is a theme that runs through students’ puzzling out connection with children and they often describe themselves as most able to maintain it in this mode of relating to children. Bowden maintains that “[t]rust is a child’s protection against vulnerability”, but continues to say that “…the tenderness with which a mother tends [her child’s] objective needs promotes the climate in which trust is an irrevocable” (Bowden, 1997:34). In the students’ current experience, however, trust is maintained in their friendships, the role in which they are most comfortable and probably also the role in which they can most trust themselves.

The process of learning, which has emerged in this study, may initially look more like a process of getting to know someone than one of learning. I would like to propose that learning to nurse is about getting to know someone. This is not a new insight. ‘Knowing the patient’ has been described by Benner and her research colleagues as central to expert nurse practice (Benner, Tanner and Chesla, 1996:20).
The essential nature of relationship is also evident in students' caring experiences with exceptional children in Beck's study (1992:363). So what then makes getting to know a child different from learning to nurse a child?

What qualifies as learning nursing is the conscious reflection, which is built into the process of reasoning and practise through situations guided by a sound nursing knowledge base. This contributes to the student's knowledge and replenishes her resources while also placing her in a relational web of people in the place where she works and learns. One student describes her experience of the difference like this:

> I feel as though I’ve made a move and I am finally fitting into the mindset of nursing children. I was used to looking after neighbour’s and friends children and somehow that’s what I thought child nursing was going to be... I was wrong. There is a different relationship involved ... different children with histories not like that of the neighbour's kiddies... (they are) individuals in need of affirmation and caring with their own unique situation that is often dictated by past experiences.... Now that I have processed that I feel more into this new experience

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This student describes her process of moving from relating to the neighbours children to nursing children. The five essential influencing conditions in this process are evident in her description. She recognises her resources and relies on what she remembers and others that were and are present to work out what she knows about nursing and takes responsibility for what she perceives the children need.

The influencing conditions in the process of learning to nurse children will be discussed as they contribute to student learning:

- **resources** - those attributes that affect a student's capacity to relate
- **remembering** - what and whether the student chooses to remember
- **responsibility** - how students perceive their responsibility and what they choose to bear
- **knowing** - that rich human quality of experience, intuition, knowledge and skill
- **others present** - who and how near others were in the situation.
Resources

This familiar word, resource, denotes the availability or source of some needed commodity, which can be either tangible or not, as has emerged in this study. As described in the findings, resources are seen as a student attribute. It emerged as a student quality rather than as an influencing condition as is often described in studies looking at stress. This is related to an understanding that individuals may attribute to derive different meanings from apparently similar situations. Consider an example: a student living at home with her parents may be considered as having a strong support base and therefore resources. One student may perceive this as a blessing and another may discern it as a burden. As their experiences and perceptions differ, so too do their resources. These are completely dependent on their perception of what they can rely on as available. Resources therefore remain something to be understood rather than predicted or explained. This perspective differs from the etic understanding of resources as the result or outcome of the more measurable concepts like threat and challenge (Oermann and Standfest, 1997).

The findings of this study suggest that the students' perceptions of their resources are more significant in their current than in their past experiences. This principle can also be applied to learning. The student's resources at the time of the experience rather than her past experience provide the context of the learning. It follows that if a student does not have the resources, or feels unsupported or without defence, she is less able to engage the situation and therefore less able to learn from the experience. The students' resources therefore represent an important platform or context for the whole process of puzzling out connection. This explains why common experience does not result in similar learning or resources in two different students.

Burns (1994), in her study with registered nurses engaging children and their parents, described that having too little time and not having energy affected nurses' choice about whether to engage with the family of not. Having energy and having time may be equated with having the resources. Burns reports that spending more time enabled the registered nurse to perceive the families' needs better (1994:114). For students in the present study time is also a resource, but for establishing the connection.
Knowing the child better was a consequence of a good relationship rather than the purpose for the relationship. The professional nurse in Burns’ study is described as engaging the parent and child with the purpose of partnering them on their way to recovery. The student, however, as learner or novice, does not see this as her task or one which requires too much time. The student’s perception of time as resource is only recognised when there is not enough time ‘to get the set tasks done’. This motivation for engaging could be characteristic of the student nurses’ learner status in the clinical setting, described by Melia as ‘just passing through’ (1983b:26). Perceived support, inclusion in the staff team and a sense of being familiar in the setting were also experienced as increasing students’ resources. These conditions certainly serve to counter or at least temper another one of student experiences in clinical settings described by Melia as ‘nursing in the dark’ (1983c:62).

In this present study student resources have been distilled from the data as having hope; a capacity for empathy and an inner strength which seems to be related to a clear sense of self and confidence in one’s ability to care. Haegert may include these in her description of “health resources”, what she describes as a “sustaining joy within a person, [which] acts as a resource in the process of care-giving.” (1999:117). She suggests that “[w]hat has to come first in any human interaction, is persons relating to persons in terms of self- knowledge and self- affirmation, self- transcendence and self- donation.”

The student or learner nurse is at best growing, discovering and building his/her sense of self or identity. The present study confirms that the setting of person-to-person interactions is rich soil for this learning of care-giving. Haegert contends that one does not inevitably arrive, or necessarily stay in this place of self-knowledge, self-affirmation, self-transcendence and self-donation. “A nurse should not stop, nor forget about, developing as a person because she is a nurse,” she says (1999:117). As described in the present study, students are in the life stage of finding and shaping their identity. A learning environment that attributes value to their exploring instils in them a culture of self-awareness. Students are often observed searching or recognising or re-gathering or harnessing their resources – their “sustaining joy”. This is most often expressed in the context or as a consequence of an engaged relationship with a child, probably after incidents that Benner (1984) would call paradigm cases.
These are the kind of incidents that students never forget and that form meaningful points of reference for them as they learn.

W...I've got a bit of a soft spot for him. So from the beginning I've been trying to get him to smile and everything. And I started off slowly; just throwing the ball to him. And he would try as hard as possible not to crack a smile. And then he would eventually started smiling. And then I got him out of bed, and I've been walking with him every day that I've been there - just to get him stronger. And now, this morning when I haven't been there for a while, it was such a nice feeling because I walked into the nurses' station and as soon as he saw me he like started beaming from ear-to-ear. Jaa, that was a nice feeling.

The consequences of engaging a child have been described as contributing to the student's resources and therefore to the context in which the next encounter with a child will happen, by implication contributing to her learning. These consequences have been described in the findings chapter as: getting to know another person, seeing the reciprocity of relationship and recognising her own significance and the solace it brings. When this happens the student recognises that the child matters and that he is of considerable significance to her. She catches a glimpse of the fact that through caring she has helped herself and the child-person to grow. She has been there for their health. This notion of caring in nursing, is described by Haegert as being about “affirming patients through the attention given to them” (1999:117).

The consequences of puzzling out connection with a child do however not always contribute to a student's resource base: all too often they deplete it. In this I would certainly concur with Burns (1994:118) in saying that “having energy is a real determinant of interaction.” She notes that being tired or distracted or encountering dissonant values, saps nurses' energy. All these were found to hold the possibility of diffusing resources in the present study. Another feature which Burns (1994:114) identifies as ‘dissonant values,’ allows further understanding of the situations, which in the present study were thought to be merely ‘complex situations’. In these settings the student can sometimes not understand or agree with the child’s parents. Disagreeing with staff values and actions also emerges as a regular cause of students' energy leaking. These disagreements or difficulties are triggered by students’ perception of dissonance related to personal as well as practice values. These were often related to issues of relationship and involvement.
Benner and Wrubel (1989; 373) suggest that the process of “finding the right level and kind of involvement show up as stress among nurses”. Students’ attempts to rescue, safeguard or to remain ‘professional’ often shows up as stress. Data from this study often reveal students’ “generalised anxiety over the demands of learning or the fears of ‘making a mistake’ (Benner et al, 1999:15). Students in this study were often so involved with puzzling out their dilemma or trying to rescue their perceived ‘failed’ attempts that this, too can drain their resources. Benner and Wrubel also describe the last resource drain students experience as resulting from “repeated exposure to breakdown and suffering” (1989:377). The discussion around vulnerability circumscribes some of the very real issues for students in this regard.

It is in the reality of constantly connecting with children in very difficult situations that I cannot but conclude that this mode of relating called distant doing is restorative and therefore quite legitimate. It is a way of puzzling out connection by not engaging. Traditional stress management strategies are often insufficient for the kinds of human suffering that nurses often help patients confront” (Benner and Wrubel, 1989:xiv). Sometimes I observed student’s distant doing while the pain she had seen still hurts too much or the ‘why?’ questions are still clamouring around the rawness of her experience. One student says: “I feel as if I am still young, but I’ve got old eyes”...eyes that had seen too much suffering. Sometimes distant doing is the only way.

**Remembering**

When asked to write something about being a child – a student in the first group writes:

**Childhood**

Once I cried ... then forgot
Once I feared ... then forgot
Once I laughed ... then forgot
Now I look back ... remember ... and smile. P1.14 journal

Remembering requires more than recalling a few facts. Palmer suggests that “[w]hen we forget who we are, we do not merely drop some data, we lose something of ourselves.[..] We dis-member ourselves, with unhappy consequences for our hearts and our work and so re-membering involves putting ourselves back together, recovering identity and integrity” (1998: 20).
Palmer’s description of “re-membering” deepens our understanding of the consequences of students not remembering. Remembering becomes more whole than just a cognitive learning process, in which students are required to store banks of knowledge onto which to keep building their learning. The process of remembering is, or can be, one by which one could be restored to integrity. Remembering and thinking about situations in this study happens when students ‘compare’ and try to ‘find the rules’.

Comparing emerged as a way of remembering when students try to make links between what they know and what they find in the encounter. It is in their remembering that they often imagine what it must be like for the child or mother in the situation. This often influences how they connect with the child. There is another remembering which helps them decide how to engage and this is their image of nurses - how they think nurses are or should be. Kiger (1993) describes student nurses’ images of nursing from entry through their early clinical experiences. As students’ images are confronted with the reality of their current experience, they find either accord or discord between the images. She found, however, that there are some aspects of students’ initial images of nursing that remain virtually intact. Three of these abiding features were “working with and helping people”, “nursing as rewarding” and “nursing as more than just a job” (1993:312). In the present study the students’ descriptions often include conversations about nurses and nursing and what it is really like or how it should be. As students compare and try to identify the ‘rules’, they explore the meaning of ‘professional’ behaviour and invariably conclude that it constrains involvement.

Kiger (1993:315) also reports the paradoxical nature of involvement in student descriptions. She also describes a form of discord which led students to a course of action called ‘constructive resistance’. When a student is unable or unwilling to accommodate the image or course of action she observes, she determines not to go along with the element that does not accord with her image. Benner (1989:373) records that there is “much discussion and practical wisdom among nurses about kinds of involvement”. In their discussion about finding the right level of involvement, Benner and Wrubel report nurses’ perceptions about ‘overinvolvement’ and ‘overidentification’ (1989:373). Later writings report nurse participants in their study warning about “becoming flooded with feelings” (Benner et al, 1999:15).
These authors have recently broadened the dialogue by introducing the term ‘skills of involvement’ as a prerequisite for “practical clinical reasoning” (1999:16). While students in this study worked at their own skills of involvement, they often saw themselves as youthful revolutionists who can resist professionalism’s constraints to involvement.

As students are encouraged to remember more of their own experience and knowing, their reflective ability develops. Initially, like with all things new, students experience the practice of nursing children as an elusive art. Like most novices, students think that there is a ‘right way of doing it’, they know it exists and that they should aspire to find it. This is another aspect of remembering and in it they continue to look for the rules of practice. It seems that once they have recognised or made sense of a current situation by remembering a similar incident, it brings a measure of safety to the experience. Data suggest that puzzling out could cease as soon as the ‘rule’ has been identified and it is difficult for some students to puzzle further once they remember or have formulated a rule. This can be understood as part of the learning of a new practice.

Dreyfus and Dreyfus (1996:37) describe that the novice is able to apply rules and principles to situations. They contend that even at the level of novice there is a level of intuition, which students may not yet have or are unwilling to trust. While seeking for rules is seen as an appropriate action while learning, students do need to be encouraged to engage particular situations further so that this mode of action does not inhibit their learning and later practice. Recent research describes that one of the impediments to nurses developing expertise, is a lack of awareness of qualitative distinctions. This seems to account for a lack of clinical knowledge among these nurses (Rubin, 1996:175). This is seen alongside another findings that the “expert nurse is able to articulate the good that she is attempting to do in a particular situation, rather than merely knowing that she is following the rule. This spares her the moral confusion of not knowing” (Rubin, 1996:184). Although these are characteristics ascribed to expert nurses they are also valuable to recognise in students. While students in this study who are obviously able to think about and articulate what they do, mostly do so, their ability to reflect is developed by questioning from a mentor. This is a process which assists them to remember and articulate their action more fully. There were students who resist most questioning or probes to articulate a happening more clearly.
These are often students who find comfort in the ‘rules’ and would most easily opt for the status quo in what they do. There are a few occasions where the data indicate that this changes after a previously painful memory is elicited. One such occasion was with a student who found herself nursing a little one who had been abused and the anger this elicits from her, brings a flood of remembering. Rubin’s (1996) observations certainly contribute to the discussion by shedding light on the consequences and nature of remembering as nurses and as students.

Certain learning activities are designed to encourage students to help them to reflect on what they know: to remember. Remembering with peers does much to engender a sense of community among students. Shared and familiar memories often result in connection. In classes of 14 to 20 students, where 3 or 4 language groups are often represented, there are also different cultures, family structures and socio-economic resource bases. What it was like going to school, being sick at home, playing in the team that lost or won the school trophy – are memories common to many students. Palmer talks about a “...culture a of fear that pervades educational settings from grade school on. [...] A fear for students of failing, of not understanding, a fear of being drawn into issues they would rather avoid, of having prejudices challenged or looking foolish in front of peers (1998: 37). In class sessions I sometimes saw these fears as memories were elicited. I remember the excitement of seeing two young people look at one another with new eyes as they recognise that both their mothers had believed castor oil to be the cure for all ailments! I also remember my own panic as the teacher when I watched unseen, the silent tears as one wrote her story among the quiet paper sounds of many others writing. Others smiled, some wrote their stories merely as a task.

In an exploration of teaching everyday skilful ethical comportment (a way of being or stance), Benner et al (1996: ) stress sharing or finding a common background of cultural meanings. They maintain that students often come with personal and also some work experience, which means that they already have some skills, such as ethical comportment (a way of doing and believing about how to do) and communication skills. This point ties in with the earlier discussion about recognising what adolescent students bring with them.
Remembering is a central step in learning from experience. Expertise grows out of a person’s expanding knowledge and experience of particular types of situations. The hardest skills to teach are those in which the learner must construct a strategy from scratch (Thornton, 1995:105). For this reason it is useful to draw on experiences of some similar situation. Memory, however, is that complex and wondrously human quality which carries not only the lesson, but also the exhilaration, the hurt, the disappointment, or anger that went with it. It seems that in this study, students choose, sometimes consciously and sometimes not, to remember or not to remember. As much as remembering can lead to restoring integrity, until the time and circumstances are safe or the student is ready, she may retain the stance of choosing not to remember. The caution offered earlier by Jenkinson (1997) related to young peoples’ vulnerability when expected continuously to reflect and analyse and criticise, is valid here. Remembering their own stories sometimes hurts too much and students choose to enter the relationship with the child with a clear slate - attempting to construct a mode of connecting or to learn a strategy from scratch.

Responsibility

Responsibility, or the ability to respond is a key condition influencing students learning to nurse children. In the context of public and personal caring, care and responsibility are complementary (Benner and Wrubel, 1989:369). The weight of responsibility that students experience is essentially related to the vulnerability of the children they encounter. The exploration of the emic characteristics of vulnerability revealed how this responsibility can be a threat to students’ integrity and they are often afraid of the responsibility.

Some aspects do bring balance to the gravity of the experience for students. Being able and allowed to take responsibility is part of how adolescent learners see being healthy (Rosenbaum and Carty, 1996). Whitbeck (1981) poses that “[a]longside creativity, responsibility is what sets nursing apart from the sentimental, self-sacrificing understandings of women’s work” (cited by Benner and Wrubel, 1996:366). Both these are evident as students grapple with responsibility, being encouraged to work it out their way in the actual situation of nursing a child seems to shift the weight in some way.
Levinas (1981 cited by van Manen, 1998:18-19) brings some understanding to this dilemma. He proposes that feeling responsible is not something you create or choose, but he says that the other (the child in this situation) is already given to the student as an “...ethical event in the immediate recognition of his or her vulnerability or weakness”. He asserts that the “ethical experience of the child’s call is always concrete in the situation where a vulnerable other bursts into your world”. Levinas uses the term ‘face-to-face’ as a way of describing the nature of the experience. In this the student cannot help but feel that the child has made a claim on her responsibility. Levinas argues that it is only at this point, when the student has already ‘been given’ the child that she thinks about what she will do, not before. What to do is therefore the student's choice not whether or not to feel the responsibility.

I was asked to help look after a six month old child who had kwashiorkor*. When I first saw her, I was too scared to look at her, let alone touch her. She had terrible oedema - she was so swollen she looked like a balloon and she couldn’t even open her eyes. She just lay there not doing anything or responding to anyone’s voice. If you touched her, you could feel the fragility of her skin. She was covered in open sores and her mouth was covered with blisters, which the sister told me was Herpes. All I wanted to do was to help ease her discomfort.

Knowing what to do is of course another of their dilemmas. Discussing the sources of moral distress felt by registered nurses, Curtin (1999) noted that nurses have serious responsibilities that are unknown to other professionals. She claims that nurses know what to do in even the simplest circumstances and that with that knowledge comes responsibility. Students carry the additional responsibility of knowing that they should do but do not always know what to do. Levinas, however suggests that in the very moment of looking into the child’s face, we “feel already addressed in our responsibility, this is feelingly knowing”. He describes responsibility as “being there” for the other. He maintains that it cannot be understood conceptually, but is a kind of moral experience that simply happens to a person. This way of describing the experience of responsibility is certainly congruent with students’ experience in the present study. Interestingly it may be their adolescent fervour to make their own choices, which causes them to believe they can choose the feeling as well as their response to it.
This discussion contributes to understanding how responsibility and knowing emerged in this study as causal to doing. It also sheds light on why students choose or approach some children rather than others. The description of coming ‘face-to-face’ with vulnerability and the feelings that this elicits clarifies their sense of responsibility. They then choose not only whether to connect or not, but also how to connect. The most vivid descriptions of responsibility as causal in the students’ interactions are witnessed in dutiful safeguarding. In this mode of connecting the student feels she knows and feels the child’s pain and in this stance of ‘over-involvement’ (Benner and Wrubel, 1996:373), she may take the role these authors describe as ‘omnipotent rescuer’. This role is characterised by a kind of ‘solicitude that leaps in to take over for the person’.

Van Manen warns that nurses can confuse the parent-child with the nurse-child relationship. At times when students try to work out to whom the responsibility of the child belongs, they do find this distinction difficult. Van Manen (1998:19) describes the relationship as being one in which the nurse’s self is erased in the experience of the vulnerability of the other. Although the present study’s students did become involved with children, the extent to which van Manen describes was not observed often. On one occasion a student encountered a very vulnerable little girl outside a clinical setting and established a relationship with her in her private capacity. However, she became so emotionally drained and distraught by what she perceived her responsibility was that she asked me for assistance in managing the situation. This level of involvement and responsibility may have been more frequent if placements in clinical settings were longer than the one month in duration. In addition to dealing with the emotions of children, families and colleagues, students are also coming to terms with their own emotional life. On occasion in this study, as Levinas predicts, this ‘self-forgetful experience’ of taking responsibility for another does have healing consequences for the student.

The responsibility students recognise in relating to children sometimes spills over into anger. The anger could be at the situation or at the mother or family for not being there. It was clear that student nurses really struggle with the concept of blame and responsibility for illness. AIDS is an example of this. The threat of AIDS as epidemic has evidenced the emergence of strong negative attitudes from both the public and health care professionals.
Particularly towards certain high-risk groups who were considered susceptible to AIDS: in the case of this study, babies of infected mothers and their often absent fathers. Recent research results show significantly greater levels of blame and responsibility associated with the person with AIDS than those with leukaemia (Stewart, 1999). The consequence of nursing children whom elicit these negative attitudes is a moral distress, which is based on the students’ perception of right and wrong. This distress is often exceedingly personal.

Responsibility signifies response to another embodying an act of care, which is relational and personal. Burns (1993:115) found that nurses ‘view themselves as responsible for initiating the relationship’. When they feel they can no longer give, they are unwilling to begin another relationship – closing down the possibility of engaging. She reminds the reader that the feminist ethic includes the responsibility ‘...that stems from an awareness of interconnection’ (1994:138).

The concept of responsibility as “feelingly knowing” (Levinas,1981 cited by van Manen, 1998:18) has been introduced in this discussion of responsibility and knowing what to do has emerged as a central question that students seek to answer as they grapple with their ability to respond. The discussion of knowing is the condition that therefore follows the discussion of responsibility.

Knowing

Not knowing has been documented as the greatest sources of stress for student nurses especially as they start working in a new setting (Pagano, 1988; Beck, 1991). This may be a new module, or different ward setting, or with children, as often in this study their previous experience has mostly been with adults. Data confirm that students sometimes feel like the speaker in this poem:

There is something I don't know, that I'm supposed to know
...I don't know what it is that I don't know
And yet I'm supposed to know it
And I feel I look stupid if I seem both not to know it
and not to know what it is I don't know
... therefore I pretend to know it.
This is nerve racking since I don’t know what I must pretend to know, therefore I pretend to know everything.

Knots – poem by Ronald Laing
Awareness of this confusion introduces some additional aspects of knowing and not knowing. Apart from feeling that they have insufficient theoretical knowledge, students also don’t know what is expected of them and often, to avoid ‘looking stupid’, they do pretend.

As they enter a practice setting, a home, a pre-school or a new ward, students often do not know what others expect of them. Although as learners they are formally allocated as supernumerary in ward settings, they are often seen as new initiates. In children’s care settings with a variable skill mix, accompanied by the continuing underestimation of the complexity of nursing children, Glasper and Ireland (1988) suggest that students are often expected to know more than they do. The fear of being caught not knowing is something that may cause students to pretend that they do know; the converse is also true, they may pretend not to know to avoid being asked or avoid doing a task.

Students were often seen relying on knowing other than what they had ‘been taught’. Van Manen suggests that there are various forms of knowledge in practice that reside beyond the cognitive, which he calls “non-cognitive knowing” (1999:5).

- Knowing that resides in action, as it is lived as confidence in acting or doing.
- Knowing that resides in the body, as a felt sense or as gestures and demeanour.
- Knowing that resides in the world, as in situations of ‘at homeness’ or dwelling.
- Knowing that resides in relationships, as in encounters with others, in relations of trust, recognition and intimacy.

Knowing in actions is often seen in students in this study as they engage a child in a certain way, for example by song or storytelling. They may do something which they have not obviously thought about, this is then action in which their ‘knowing’ resides. They do see the outcome and are sometimes surprised by it. Students also display "knowledge that resides in the body" as they pick up a child or reposition a struggling little one only to find him settle in an unexpected way. This kind of knowing cannot be explained but is felt in the physical closeness of the child. It is a knowing more often described by expert nurses.
Benner describes it like this: “Nurses meet the patient and family as persons by being physically comforting in their style and tone, talking and through their way of being” (Benner et al, 1999:258).

Another characteristic of van Manen’s non-cognitive knowledge is knowing that resides in the “world or in being in a space”. This knowing is also evident among students and it is more often seen rather than described by them. It includes the knowing how to be in a room or playground with children or maybe, not knowing how to be there. The last of van Manen’s forms of knowing - that which resides in relations - is often seen as students learn to nurse children. This knowing resides in being with others; sometimes with a fretting child the knowing is calmness, with a despairing child knowing is quietness and presence. This knowing is not easily explained or taught; it is more easily recognised and accrued as knowledge and experience. In describing this kind of knowing van Manen argues that the whole body is cognitive, thus “[i]t knows how to do things” because it provides access to our world (1999:6).

Not surprisingly therefore, it is in student nurses’ practice - the actual being with children, with people - that students access this knowing. Palmer (1983) asserts that relationships, not facts and reasons, are the key to reality and as we enter relationships, knowledge of reality is unlocked. There is certainly evidence of this in this study. Palmer’s contention that our knowledge increases as our capacity for conscious and reflective relationship increases, resonates with van Manen’s concepts of non-cognitive knowledge.

In this study, the unexpected, unexplained and often unvalued part of knowing that is so difficult to measure, except in the students’ growing levels of confidence and satisfaction are seen as the consequences of engaging a child. The extensive work of Benner and her research colleagues has demonstrated that nursing knowledge is “socially embedded” (Benner et al, 1996:193). “Strong clinicians embody the best of nursing practice based on extensive cumulative knowledge they have gained from experience and the science” (Benner et al, 1999: 490). This study indicates that this extensive knowledge starts accumulating much earlier - for some students while they watched or experienced being mothered themselves.
The assertion that "...[t]he clinical judgement of experienced nurses resembles much more the engaged, practical reasoning first described by Aristotle, than the disengaged, scientific, or theoretical reasoning promoted by cognitive theorists and represented in the nursing process" (Benner et al, 1996: 1) is significant. The initial description and motivation for the curriculum in which the students in this study now learn (Skeet and Thompson, 1985) was based on this very principle. We should expect students to learn best in settings in which they encounter real people where they can recognise what the theoretical concepts they acquire in the classroom setting look like. Although skilled knowledge includes formalised knowledge and skilled know-how - "expert nurses embody rather than master expert knowledge" (Benner et al, 1999:13). This too was a basic premise in the development of this curriculum, that students require opportunity to bring "what they already knew from life experience, instinct and intuition" (Skeet and Thompson, 1985: 15) to their learning. Van Manen adds that our knowledge resides intangibly in our relations with others and this leads the discussion to its conclusion with others present.

Others present

Van Manen (1999) introduces this condition of the presence of others with a question which many students - and certainly these in this study have probably asked:

Why is it that in the presence of one person we may feel totally stupid while with another we may feel really smart? (van Manen 1999: 60)

Van Manen notes that in interactive relations we seem to be tied up in the total conversation of the person with whom we speak and to whom we listen (1999:60).

In this study students seem to be tied up in conversations almost all the time. Engaged in a learning process which has puzzling out connection at its center, constant conversations are probably inevitable. Analysis shows that in some of these conversations they feel really smart - knowledgeable, supported and successful, while other conversations are more likely to contribute to their feeling 'totally stupid' and inadequate. Both these types of conversations significantly affect the process of their relating to the children.
I would like to include relationships with four groups of others in this part of the discussion: peers, staff, parents and the teacher. In the previous chapter (findings), the mother was included with the child as the context of the students’ puzzling out. The significant finding that the presence of a mother was the most likely factor to deter a student from approaching that child, makes her presence important to this discussion.

1. Peers as others present

The essential presence of peers in this developmental stage has been discussed extensively in the section exploring adolescence. It was previously specifically related to students’ identity formation, but peers as present or ‘near’ others had further value in this study. Peers are not only present in the classroom and in the clinical setting, but also in the students ‘home’ and social setting. Most students reside together in a hospital residence and they are probably ‘nearest’ in one another’s learning process. Students most often expect their peers to share their knowledge and to work alongside wherever possible. As in Campbell et al’s study (1994:1130), it is important for them to know that their peers shared their anxieties and aspirations concerning nursing care.

Studies explaining student learning, both experiential and other, rarely do more than mention peer presence in the process or experience of learning to nurse. One study, however, found that peers were viewed as a valuable resource in the clinical area (Campbell et al, 1994:1128). Their study was part of a bigger study looking at socialisation into nursing and the role of peer support revealed three dimensions namely, facilitating learning, providing support and assisting with physical tasks. These are similar to the two aspects of expectations and support which emerge from the present study. Further reference to peer involvement in learning comes from the related yet different fields of psychology and education, which contribute to understanding cognitive abilities and development and are related to teaching methods and learning. Recent years have seen the emergence of “co-operative learning” as a methodology. Much is also written about small group learning methods, like problem-based learning which utilise co-operative learning as a method. Understanding peer relations among learners, however, remains important for utilising these strategies and contributing to the knowledge base of learning.
The importance of peer relations in the present study would support Campbell et al’s (1994: 1131) recommendation that providing opportunity to develop close social relationships is critical to establishing and maintaining peer support in the clinical setting.

2. Staff as others present

Much more is written about the influence of clinical mentors than unit staff per se on students acquiring clinical nursing competency. A great deal of the uncertainty towards and by student nurses in a clinical setting seems to be related to their fundamental way of being there - termed ‘passing through’ by Melia (1983b:26). The student seems to take on this stance as she knows that she is a transient team member. The student’s expectations are more likely to be guided by the classroom than the clinical situation.

Uncertainty about the staff’s expectations adds to students’ uncertainty especially of starting in a new clinical setting (Smith, 1992:119). Staff expectations of students may be unrealistically high (Smith, 1992) or when the complexity of child nursing care is underestimated, they can be seen as an extra pair of hands (Glasper and Ireland, 1988:13). The view that students are initiates entering the profession who need to be moulded, is still prevalent in South Africa. This could result in educational or learning needs being ignored at the expense of socialisation. Pam Smith’s (1992) work indicates that the key role of the ward sister is setting the emotional tone of the ward. This team leader’s style determines whether the student’s individuality is encouraged or repressed and whether the student can resist the weight of the hierarchy by learning to harness her own personal resources to meet the patients’ needs (Smith, 1992:1). In the present study students did see the ward sister or team leader as supportive if she is caring and her expectations are clear.
Research also reveals that the reality of the practice setting can be shaped by what others do to reinterpret practitioners' interventions and their meanings of care and caring. Institutional caring often falls below the practitioner's ideal and students, as new entrants, can be affected by the mixed messages they receive (Haegert, 1999:163). In Kiger's study (1993), students' image of nursing were found to be influenced by what emerged as properties of "good staff" and "bad staff". The present study also evidences students categorising staff according to their caring attitudes towards children or other patients. Although the latter findings are not evident in Kiger's study, students share the perspectives of 'good staff' being welcoming, providing support, including and assisting them and providing a happy atmosphere (Kiger, 1993:312). This aspect of a happy atmosphere is synonymous with harmonious team relationships a feature which Smith's study also confirmed (Smith, 1992: 119).

'Bad staff' were described as those who are unfriendly and not welcoming, who treat students as outsiders, give no praise or acknowledgement and often give students the 'dirty work' (Kiger, 1993:312). In the present study students add that the staff are absent from the child, therefore leaving the student with the responsibility of managing alone. Often this forces students to manage, sometimes even excel at attempts not only cope but to connect with the child in different and compensatory ways. The absence of staff often seems to elicit a determination to succeed. The unavailability of the ward sister affects the students most. This is because they see him/her as their role model in the clinical setting. Unlike the teacher/mentor who comes and goes, the ward sister is engaged in the actual 'doing' of nursing children, although in reality she is more often supervising. Students' determination to cope or to show that they are able was often in response to the availability of other resources or others present, like peers, is often seen in the data. Students in this study often report their victories in connecting or caring for a child despite the staff's absence or disapproval. This may be indicative of adolescents' expectation that adults have little confidence in their ability and that adults do not to understand them (Rosenbaum and Carty, 1996).
Absence or distance of staff does not always engender these heroic responses, however. Students’ report increased anxiety when left with the responsibility of decisions and caring. A study about student nurse perspectives of clinical learning showed that students’ foremost goal was “to do no harm” (Wilson, 1994:83). In the present study, too, the possibility of doing the wrong thing caused increased levels of anxiety for students lest they harm the child through their lack of knowing. Another significant student goal highlighted in Wilson’s study was “to look good as a nurse”. This usually evokes praise from the staff, their peers and patients. Praise helps students to develop their inner sense of self-confidence and competence. Absent staff cannot see the “good nurse or student” and students therefore forfeit this feedback. The potential for having the good you do go unnoticed or recognised means that students can slip into knowing that the bad will not be noticed either. This has the potential to diminish their sense of responsibility and also their sense of moral and ethical practice as they lose the benefits of learning alongside others who know nursing.

A recent South African study (Haegert, 1999) exploring registered nurses caring in settings similar to those in which the students in the present study learn, revealed that many nurses are not able to practice in the way they described as their ideal or according to their intrinsic capacity. Severe financial cutbacks, resulting in marked staff and other resources constraints seemed to exacerbate this. Yet registered nurses were reluctant to speak of these factors as curbing care and they rather blame themselves. They spoke not of the ‘right or wrong’ of the situation but directed anger at others - administrators and managers- who avoid including them in decision making. (Haegert, 1999:162). Haegert describes the climate and context of institutional nursing care as ‘swampy ground’ of cutbacks, personnel shortages and systematic nursing approaches which inevitably has an effect on the ‘presence’ of staff for students in these settings.

3. Parents as others present

Much of the writing of scholars about parental involvement in the care of their hospitalised children has found resonance and confirmation in this study. Findings may also offer additional understanding of learning to work with parents and children.
Despite three decades of research, writing and attempts at changing practice there is still concern about the gap that exists between the theory and practice of parental involvement in care (Knight, 1995:32). Although participation approaches are widely taught and apparently accepted, recent studies suggest that nurses in hospitals continue to perform routine, mainly physical care with little involvement of parents and relations. Casey suggests that the imbalances of power and professionals’ control over information are contributors to this discrepancy (Casey, 1995:1058). Evidence of both these conditions was found in student experience in the present study. The interesting aspect of their encounters with mothers however was that they are more likely to identify with the child’s mother due to their own low position on the pecking order. Palmer reminds that students have been the quiet recipients in education (1998:38) as such they perceive themselves as powerless and from within this position they may identify with the mother if she is with the child. If, however, the mother has left the child, they identify with the child. As is evident from analysis of this study the presence of the mother is also the student’s biggest deterrent from approaching the child. These two assumptions may seem to contradict one another but it is suggested that they embody different intentions or motivations. If the student compares her and the mother’s knowing, the mother must know more. She knows how ‘to do’ for the child as well as how ‘to be’ with the child - both things which the student, is challenged to learning.

As she finds herself in the presence, of the knower she retreats. A mother who is apparently less knowing, like a very young mother or one who visits for the first time after the student has engaged the child is more likely to be approached. Casey adds to the discussion here by suggesting that the degree of two-way communication that occurs between nurses and families determines involvement of the family (1995:1060). In the present study the difference in language between mothers and students is a deterrent to two-way communication and probably also to students approaching the mother. Casey’s study also suggests that a major influencing factor in participation is whether the nurse works in a nurse-centred or person-centred way. The modes of engagement students in the present study choose indicate a nurse-centredness if their motive is purely to get the job done or person-centred if they try to engage the child.
Another aspect of the mother’s presence for the student is her disposition. The mother’s anxiety in the foreign environment, her experience of responsibility or guilt concerning her child’s admission to the care setting, her sense of being torn between being with this child and with siblings at home, all result in anxiety and ambivalence which the student must perceive. Sometimes the complexity of the mother’s position or disposition is sufficient to deter student approach or engaging. The student may fear being asked for information she does not have or even have access to. These are realistic fears as studies looking at families’ responses to illness or injury indicate that parents always have a strong need for information. Gibson describes that mothers of chronically ill children generally recall having experienced anxiety and frustration when they did not understand what was happening (1995:1204). In this position the mother is also less likely to reach out to the student by appearing welcoming.

The mother or parent’s position is a very important one to consider in participation in care. Even though the study evidences that students are likely to engage parents in a way described as in relay with the mother’ this is not the same as partnership. Rather the student may see herself as participating in the child’s care but also as a visitor to the situation. This is a different stance to that of the more experienced nurse who may see the family as the visitors to the context of the child’s care (Benner et al, 1999: 301).

An accepted theoretical perspective of family centred nursing may cause the student to assume that all families want to be involved fully even to the extent of directing care. In her review of the nursing literature regarding parent participation, Coyne found that the abilities and willingness of parents to participate in care varies enormously (1995:717). In the present study students do describe their bewilderment at parents who prefer to go home, regarding the nursing of their children as ‘what nurses are paid for’. The bewilderment can sometimes be traced to becoming angry when a child is left for long periods of time with no visiting by parents. Students are often seen choosing the option of ‘dutiful safeguarding’ in caring for these little ones.
The presence of the child’s mother is obviously central to the student’s learning to relate and nurse a child. Not only does the student puzzle relating to her in ways reminiscent of a child relating to an elder, or a peer in the case of adolescent mothers, but also in more professional ways of offering information and assistance. Roles of coaching are also sometimes seen. Much of their puzzling how to relate to the child has aspects of puzzling out the differences or similarities between nurse and mother roles. As indicated before, however, in the discussion surrounding responsibility it is important that there is a clear distinction between the nurse’s role as ‘nurse’ and as ‘parent’. Journals and class discussions often include conversations about understanding and becoming comfortable with these roles.

A concept analysis of parent participation has revealed that there is not a clear definition of or understanding between partnership and participation. It seems that the concept ‘parental participation’ has evolved from parental involvement to partnership in care and finally, become family-centred care. Family-centred care may also preclude parent participation if this is not deemed conducive for healthy family functioning in particular circumstances. (Coyne, 1996:739).

Consideration of these issues is important in changing health care structures. Understanding students’ experiences contributes to their preparation within the theoretical context so that they are better prepared for practice. In this regard it seems imperative that students are coached and encouraged in person-centred approaches to care - approaches that will enable them to listen to each mother, each child, each family’s story to understand better as they work out the best care together.

4. Teachers as others present

Along with Parker Palmer, I have also come to understand that “...[t]eachers possess the power to create conditions that help students learn a great deal - or keep them from learning much at all” (1998:6). He defines teaching as the “...intentional art of creating these conditions.” In this study, the students’ experience and expectations of enabling conditions lies in their descriptions of the teacher as present other.
Analysis reveals that for these students, the teacher's work is centred around two processes, helping them to make sense of their learning and making space for them to learn in different relationships.

The discussion of the teacher as present other will include how students perceive being supported by the teacher's presence, their expectations of the teacher and the complex nature of being present while being evaluated.

The Oxford dictionary defines a teacher as one who enables or causes by instruction, (1982:1097). These can be seen as two complementary but equally important actions. Instruction involves tutoring, demonstrating, interpreting and initiating. The enabling occurs as the teacher guides, ministers (serves) or coaches. During the course of this study it becomes more and more evident that the activities which occur in the classroom setting are but a portion of this work of the teacher. In that place there is certainly instructing: introduction of new knowledge and many attempts at assisting students to adapt what they knew in order to apply this to their learning. The rest of the work of teacher, both in the classroom and in the clinical setting in this study is that of ‘coming alongside’. The actions defined as guiding, ministering, coaching and demonstrating often happen with students in the settings where they were puzzling out their connections with children. Data analysis suggests that this presence or nearness assists students as they made sense of situations in these settings. As has been described, the presence of others assists students to clarify their expectations and elicit support. While the teacher in this setting specifically assists them with making sense of the situation, this is often achieved by being supportive and meeting student expectations of being a knowledgeable other, from whom they can expect to learn.

This confirmed findings from a study by Campbell et al (1994:1127) in which students acknowledged the need for classroom instruction but felt that practising faculty members played a major role in shaping their attitudes in learning to nurse. The authors identified that clinical instructors were important transmitters of knowledge among student nurses. Along with students in various studies (Kiger, 1993; Cahill, 1996) students in Campbell et al's study were able to identify good and bad role models. Good role models enjoyed nursing; they did it well and were seen as good teachers.
These teachers’ other attributes were clearly identifiable as part of their teacher role: they were also impartial and showed no bias to students. Students contrasted them with teachers who did not allow independence and were critical; these often elicit fear and anxiety about failing or not doing well. Identifying this aspect of good nurse teachers: that they see nursing is a worthwhile profession and live accordingly - concurs with Palmer’s conclusions about good teachers. He found it was difficult to isolate the common characteristics of good teachers. The one that seemed to stand out was a strong sense of personal identity (1998:10). He found that while bad teachers distance themselves from their subject and simultaneously from the students, “...good teachers join self and subject and students in the fabric of life” (1998:11). It is reasonable to assume that the nature of such a presence in the real context of nursing practice facilitates students making sense of their learning there.

The nature and value of support is traced throughout aspects of others present for the student in the study. Students’ expectations of the teacher as other present are no different. Like in other studies, they frequently feel vulnerable in the hospital, in part because they were learning to provide care but also because they are concerned with the reactions of the nursing staff to their efforts. Campbell et al (1994:1128) emphasise the importance of staff-teacher relationships in creating a positive learning environment. They also found that “...practising faculty had a stronger influence in shaping students’ attitudes towards nursing than classroom teachers’ (1994: 1131). Although the practical implications of this have been considered in various models, this and other studies confirm that continuity and sustained relationship with a mentor or teacher contribute considerably to student learning. In a study with students who have short-term mentors assigned in the practice setting, a major stress was lack of contact with these mentors (Cahill, 1996: 795). These nursing students separated learning experiences from patient care. Their experience of their mentors or clinical teachers was that interactions were mostly for the purpose of evaluation and therefore not always supportive.

In the present study the support from the teacher was more often described in helping the student to make sense of a real situation with a child than in settings involving evaluation.
Having (the teacher) with me this morning helped a lot—although positioning Morton (a child with cerebral palsy) is still a difficult task. Feeding him is difficult too. I notice that nurses try for only a very short while before removing the food. Having you there when I was trying to feed showed me that perseverance works (maybe not always and not completely, but to a degree it works).

Interestingly, being present does not necessarily lend support by solving or providing answers, but instead, it assists students to work it out further. Sometimes the situation enables them to revisit something that they have been puzzling about for a while. It may be something they have previously mentioned in a journal or which is triggered in the course of this interaction. The element of coaching or serving a student may be seen as coming alongside to enable or strengthen their resolve, in essence to provide support.

Cope, Cuthbertson and Stoddart reiterate that the nurse teacher is charged with ensuring that students learn the "...necessary practical skills, which are underpinned by a well developed knowledge base" (2000: 851). The students' expectation of the teacher's support and 'coming alongside' in the present study display this as central. This expectation of the teacher, not only in the clinical setting but also in all learning, seems to shape student attitudes by encouraging and reinforcing their learning. It is now recognised that students cannot learn technical skills effectively independently of social context (Lave and Wenger, 1991 quoted by Cope et al, 2000). In this study the teacher is a key feature of the social context of students' learning. This further complicates the teacher's task, if not only in time and place, also relationally.

An additional complication of the presence of the teacher described by other authors, is related to evaluation of student progress. While a teacher's presence and listening ear validate the student's sense-making and is a supportive presence, students also carry an almost inherent awareness of having to make the grade. Cahill (1996:795) found that a striking feature of student accounts was "...the anxiety provoked by their preoccupation with receiving a good report...." Students in her study also expressed their fears that personal differences between mentors and themselves would interfere with their chances of a good report. These fears were heightened within "dissupportive relationships" with mentors. Wilson (1995:83) described this aspect of looking good as one of the six goals she isolated when describing student nurses’ perspectives of learning in a clinical setting.
Looking good was an essential part of becoming a nurse; students wanted to get good grades and to stay in the programme. Students in Cahill's (1996) study describe a constant awareness of being watched for evaluation. In the present study students do also describe anxieties about having to do something while being watched. There are also anxieties about 'becoming competent' in a relatively short period of time. This certainly complicated the experience of others present, as well as the teachers awareness of being that 'other'.

In the teacher role of serving and coaching the teacher enters a position of commitment and trust with the student. This is one that entails a commitment to arrive, which in essence, is more about nearness than merely keeping an appointment. In this excerpt, the student indicates her awareness of the difference between learning and being evaluated.

\[\text{(student) felt very disappointed when you (the teacher) didn't arrive for slot. [I had] thoughts, for example, how are we supposed to learn to nurse children if we don't have appointments with our tutors? ...Anyway, thank you very much for coming (later). Realised in this case that I learned from being with both children instead of just focusing on my assessment, as well as not being preoccupied with preparing something.} \]

This role of 'being with' does not always mean being present at the time. Those students who feel comfortable enough with the teacher will tell their stories, either in person or in their journals and receive the dialogue which follows as an experience of 'being with' the teacher:

\[\text{(I had been quite good at writing entries in first and second year but somehow they just served to get rid of feelings and off load frustrating days at work ...- I never really used them as tools for learning. During these past three months you have enabled me to see reflective practice as a process, not isolated incidents just lumped together but a journey of growth involving thoughts, feelings, insights and experiences. This method of reflection has certainly enriched my nursing practice by allowing me to become more conscious, analytical and constantly assessing.} \]

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As I consider the findings of this study, I must therefore conclude that teaching is a relationship that exhibits elements of trust and commitment from those learning, both those learning to nurse children and those learning to facilitate this better. Affirmation of this is not always verbal, but teaching is about prompting and challenging.

Thank you for being my 'mentor' through this process, for prompting and challenging me to analyse things more fully. Your comments and questions encouraged me to move one step further to grapple with issues and seek answers. This certainly has been an invaluable learning experience for me which has developed skills and abilities I never knew I possessed.

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CHAPTER 7

Puzzling out connection: learning to nurse
"...looking back now I can see...it was all about learning, coping, caring and growing."
From a student journal as she reflects on a placement

The weaving is almost complete. The threads of interpersonal relationships with children must now also be woven into the richness of learning and what others have constructed as current educational theories and theories of learning in nursing education, especially as this relates to learning about children.

I started the last chapter with my observations of what I have come to understand about the nature of student learning. In essence I have seen that: learning to nurse children is about learning to connect. I have also come to realise that within a culture that places an extraordinarily strong emphasis on achievement by measurable grades, relationships are largely taken for granted and consequently remain ‘invisible’.

This recognition of the visible and invisible has featured throughout this discussion as the difference between the public and private realm, particularly concerning relationships and caring (Benner and Wrubel, 1989; Bowden, 1997 and Haegert, 1999). It seems to me that interpersonal relationships are a domain about which nurse authors know a great deal and therefore often describe: my overflowing files are my personal evidence of this. I think our inclination to write about relationships - relationships in our practice, with people (ill and well), spouse, family, parents, siblings, community, management as well as relationships in educational settings, among teachers, faculty and students - all indicate our awareness, commitment and essentially the central context of our practice as nurses. But invariably a question that remains unasked and unanswered is “How do we do relationships?” Once we have started considering this question, another will follow “How do we measure or evaluate relationships as a legitimate nursing skill?”. This chapter goes a little way towards answering the first of these two questions. The second is touched upon but both require more research and debate.
Understanding a small group of students’ learning was the central question of this inquiry. This chapter will describe the nature of learning as it has emerged. There are existing models of teaching and learning, which have entered the debate of the curricular paradigm shifts especially in the last two decades.

These will be considered alongside a relational model from the field of economics which could bring us, closer to the question of “How to do it”. The chapter is concluded with a consideration of the challenges for faculty and individual teacher in this relational model.

- The nature of learning in a relational context
- Current theories and models relevant to learning nursing
- Why are shifts from the theory to the practice of education difficult?
- A Relational Ethic in learning to nurse
  - Communities of care in learning to nurse
  - The ‘who’ and ‘how’ of the teacher
The nature of learning in a relational context

We have considered the context of learning: the nature of caring for children and students, their others present and those conditions which influence their actions and situated these findings in the broader literature. The way students learn now has a rich context for discussion. The four modes of interaction the students' use with children in this setting, are related to how they learn.

How children and young people learn has fascinated observers for centuries. While parents' observations are used to compare and understand their children, more scholarly observations have yielded a multiplicity of theories. As various academic disciplines developed, findings in one discipline would contribute to understanding in another. Theories of learning seem to have been housed in the cognitive domain for the initial part of this development. Psychologists offered an understanding of learning as developmental ability or progressive maturation. Sociologists and anthropologists have contributed to this body of knowledge by broadening the understanding of learning to include social constructs. Educational theories have further developed these understandings and contributed a rich tradition of practical experience.

In this study, informed by a theoretical framework from the discipline of Nursing, a process of learning called *puzzling out connection* has emerged. Three aspects are distinctive of learning in this setting:

- Learning by being involved
- Learning by being touched
- Learning by a kind of reflection
Learning by being involved

The metaphor of play has been traced throughout the process of students' puzzling out their connections with children. The theories of Play, similar to those of Learning, can be traced along a path dominated by two main paradigms. The first, found mainly in the philosophical and psychological literature from as early as the late eighteenth century, holds that "... play is voluntarily and actively taken up and results in gains either in cognitive or creative organisation". The second found in "... anthropology, folklore and socio-linguistics, contends that play is a way of organising collective behaviour, that it is a form of human communication and that it reflects the enculturative process of the larger society" (Sutton-Smith, 1979: 17).

Why compare play and learning? The students in this study are essentially involved with what is central to both these theory bases. Theirs is an enculturative process into the discipline of nursing. Although, unlike play, it is not always "voluntarily taken up", it is a process in which students gain cognitive and creative organisation. Students try to solve the puzzle of connecting with children, a process beyond basic cognitive competence. Thornton (1995) uses the context of problem solving to bring together the cognitive and social aspects of learning in children. Two aspects of the nature of learning in children contribute to understanding of adolescent learning in the context of this present study.

The first is related to learning the principles of nursing knowledge. Thornton (1995:105) says that "[I]earning an abstract principle from concrete examples is more complex and subtle than learning a concrete skill". She has observed that if children learn concrete skills, two things happen: the child "remains separate from the experience and the principle is not easy to extract, it needs to be learned anew at the next encounter". This is found to be true in this study. If students learn only a concrete psychomotor skill, they remain separate from the child and their experience of illness. Adapting the skill is as difficult the next time. Like children, students also find it easier to learn in the context where they understand the goals that motivate their actions, rather than when the goal seems meaningless. As described the students' goals were most often to connect although sometimes getting done would suffice. Understanding the meaning of a task seems to motivate them to persist and to pay attention, both key learning factors.
It is evident that the puzzling out behaviour that students display, is worked out in their connecting with children. It is often in the 'being with' that they work out the meaning of their task, here "knowledge resides in relations" (van Manen, 1999:5)

I spent some time sitting with him after he had refused the lunch I had offered him and I began to discover that Darren (a 9 year old with haemophilia) was actually experiencing real loneliness and isolation. Being away from school and friends at his age was traumatic and he was struggling with the restrictions placed on him by his illness. After talking to him I realised how often we think we know what's wrong with children and how often we are wrong. P3.1 journal doc. 1290-1295

Patricia Benner and her research colleagues offer the understanding that there is a distinction between engaging a problem and the skills of involvement nurses require (1996:xv). In this study the skill of involvement - 'connecting' was often the goal of students' problem solving -or their 'puzzling out'.

The second aspect is that adolescents have "richer presentations", unlike children who are described as "universal novices" (Thornton, 1995:72). This means that there does need to be an acknowledgement of the breadth of experience these students have. Unlike adult learners, however, these adolescent learners' presentations are gained in growing up and do not include experience of independent adult or work life. Therefore, as for children, a key part of becoming a mature problem-solver is learning the shared assumptions and meanings of the culture. So for students changing strategies of engaging children is about making sense of things in the social context of nursing. This grounds or underpins the importance of this learning alongside others which has already received some attention in the section on 'others present'. Like children, students learn a lot from watching others and when working together (as children play together), students are seen sharing the task of solving the puzzles of connecting. Even when neither of two peers starts out with expertise, a pair is often more successful than an individual (Doise and Mugny, 1995). Here again the understanding of nursing having a 'socially embedded' knowledge base is helpful.

The nature of these students' learning can thus be described as being involved with people. As noted by Benner, it is evident that engaged practical reasoning is more valuable in learning to nurse than uninvolved theoretical reasoning (1996:1).
The contexts of real situations with children, in which students are actually and legitimately involved as team members and learners is the context in which the “practical reasoning” can occur.

As nurses we are so focused on making people better that we often feel overwhelmed and powerless when we can’t. There is nothing one can say or do to make things better in the face of such pain. This is the reality that often causes nurses to distance themselves from their patients. However, when we understand that we are not responsible to take away the pain and that the child or family is not expecting this, then we are able to care, share the pain and provide support without being overwhelmed.

The understanding of this learning emerged from observing what students do rather than from measuring cognitive processes. And yet this involved, relational learning has elements of all three of the traditional domains of learning: the cognitive (facts, understanding and application), the psychomotor (imitation, practice and habit) and the affective domains (awareness, distinction and integration) (Cerny, 1997). The latter are different descriptors to the more familiar: feelings, values and attitudes, but Cerny’s descriptors allow a fresh perspective of the domain of the affect. The psychomotor has traditionally been seen as the predominant occupational preparation domain, which is why many traditional nursing programmes place such emphasis on the acquisition of skills. The often authoritarian atmosphere of nursing schools in which students must “learn to do” shapes and reinforces the passivity among students and in fact prepares them to be compliant workers (Allen, 1990: 315), rather than the involved practitioners required to engage a variety of people differently in care settings. In many clinical settings conformity and obedience are still highly prized, even if lip service is given to creativity and diversity.

Many nurse scholars have explored the links between the practice and theory of nursing (Boykin & Schoenhofer, 1991; Campbell & Jackson, 1992; Dreyfus & Dreyfus 1996). There is also the resultant questioning of learning this practice discipline which is exemplified in the work of many scholars often teachers of nursing (Beck, 1992; Kiger, 1993; Finn et al, 1994; Redmond and Sorrel, 1994; Campbell et al 1994). The research of scholars like Benner (1984) continues to describe the practice of nursing and contributes to our understanding of the nature of learning to nurse. As the craft of the discipline is described, so our appreciation of the nature of learning to nurse is enriched.
Benner holds that caring practices, like nursing, require skilled relational and practical know-how (1996:xv). In her work with Tanner and Chesla she describes the development of novice to expert nurse practitioners, offering further understanding of what the student nurse should be prepared for. This work emphasises that there is a distinction between “knowing that” and “knowing how” (1996:308). Questions that students in this study ask early in their experience indicate that they are aware of these differences. Benner and her colleagues describe numerous shifts in thinking and practice that are evident as nurses become expert nurses. It seems that the ground for these shifts can be prepared in undergraduate programmes if students are encouraged to remain involved with people and relational learning is recognised and facilitated. This perspective is one not yet well described in the literature or the practical outworking of nursing curricula. The risks of involvement may be held up as warning: burnout, loss of perspective and obviously the increased responsibility for facilitation and reflective student learning which rests with the teacher. At the UCT Department of Nursing, we hold that “[s]tudents must, from the outset be in close committed contact, with people in their normal world” (Thompson, 1986:6) and the challenges of involvement continue to be worked out by both teachers and students.

Learning by being touched

‘Being involved’ in learning inevitably results in ‘being touched’ by the child and the situation. How the student is touched often depends on the current circumstances and on what is happening with the child. It also depends on what most affects the student in the circumstance, what touches her most.

This touching can be in various ways. Mostly a student’s emotions are touched, as she feels deeply. The emotions can range from deep sadness to real joy, or fear and anxiety.

Student 1: I also learned how to care for sick children by being scared of them.... when you see something you’ve never seen before, like that baby with Anencephaly* There was no covering(skull)... no bone so it’s just the soft tissue. Now you can imagine all the soft tissue lying like this - brain tissue. In a little incubator, but when you feed it you take it out. You stand there and you think: How do you touch it? You can’t do it.

Interviewer: And you had to pick the baby up?
Student 1: (while nodding). So that means taking a towel and taking this soft, gooey mass in your hand - and keeping (holding) it on(near) you - which does not feel like a baby. And then give the bottle!

Interviewer: And that is scary?
Student 1: Yes, scary stuff.

Benner (1997, in personal communication) describes that: “the emotional response gives you a grasp of the setting and emotion offers a moral lead or a compass”. Being touched in this way helps the student decide what to do. Physically they were often either touched by fatigue or a sense of renewed energy. The student’s intellect may be touched as she is challenged to reason out a situation or challenged to understand it.

There is also a spiritual dimension to being touched. This is seen when students describe their recognition of participating in some kind of higher purpose either touching themselves or the child. In these times they may know that prayer or remaining beside the child is what the particular situation requires and in this experience there is a different kind of learning than the learning by doing, which was more frequently seen.

...a seven year old boy with terminal metastatic hepatoblastoma*. It was quite a shock for me to see a boy of that age lying in bed completely unresponsive…. Later on during the day…. I sat there for what seemed like an eternity with one hand holding the tube feed and the other holding his hand. Despite him seeming physically far away I felt a closeness with him. I wanted to just sit and hold his hand all day because he seemed so peaceful and calm.

The students also describe being touched in what can be described as their relational being. This is often seen in how students identify with the individuals in a situation. It is in the experience of identifying with others that causes outrage at what others are or are not doing as they work with children. Sometimes they identify so closely that it is the sense of belonging which most touches them. It seems that the aspect of being touched is a strong indicator of learning. It is often the trigger for reflecting and for puzzling out connection with a specific child.

This being touched can be compared with van Manen’s concept of ‘non-cognitive knowledge’ introduced earlier in the discussion of student knowing. These forms of “knowledge in practice” that he describes as inherent in our actions, our body, our relations, and the things around us (1999:5) are often visible.
This kind of knowing may also be what Skeet and Thompson called instinct and intuition (1985:15). It seems that 'being touched' triggers this kind of knowing.

Students' descriptions of reciprocity in the face-to-face of a situation often caused them to engage the child. Being touched is also the beginning of “agency” a term used by Benner to describe “how you understand the difference you make” (1996:90).

Learning as a kind of reflection

So learning is about being touched when involved in situations, and occurs by thinking about doing or having done. As expanded in the findings in Chapter 5 it is evident that each encounter with a child contributes to what the student will do when she next encounters a child. This is not an unusual description of learning. As consequences of doing become the intervening and causal conditions in the next encounter, students learn. They learn by doing and thinking about it and it seems that they reflect on each interaction at two levels. Firstly, by assessing the cues they receive from the child and secondly, assessing how this interaction has left them feeling. This influences the next interaction, the way they see themselves and the way they understand children to be. There is also evidence, as has been discussed, that they compile their knowledge and skill base from their interactions. They work out what works from what they do and they decide who helps them in connecting most successfully. And therefore it is clear that they are working out how to do it better in the next encounter.

In the process of puzzling out their connection with children, students draw conclusions. As they learn more about 'how to do', they think about and decide how to engage differently in the next encounter with a child. In essence, this learning is a kind of reflection.

In the theories of reflective practice learners are encouraged to reflect, or: the situation and in so doing, think through the process. This is what the students were being asked to do in their journals. Van Manen points out that “[t]he temporal dimensions of the practical contexts in which reflection occurs can complicate the notion of reflection” (1995:34). He has written extensively about reflection and like Schön (1983), he considers how reflection is utilised in practice.
Remembering as conceptualised in this study can be described as "retrospective reflection". This is reflection on known or past experiences and is distinguished from "anticipatory reflection" on future experiences. A third way of reflection, called "contemporaneous" by van Manen, is akin to Schön's concept of "reflection-in-action". It is that which occurs in the situations which "allow for a 'stop and think' kind of action" (van Manen, 1995:34). Both the latter and the "reflective awareness", which van Manen describes as reflection in "the very moment of acting", are complex ways of reflecting in practice which have been described as characteristic of expert practitioners. Van Manen has explored the practice of expert teachers and coined the notion of "pedagogical thoughtfulness and tact". Benner and her research colleagues have extensively described what they call "thinking-in-action" and "reasoning-in-transitions" of expert nurses (1999:10). Much of the acquisition of these levels of expertise lies in experience, and requires a particular awareness from the practitioner and a committed presence in practice.

Data in this study do not evidence this complex reflection-in-action. Evidence of reflection is mostly seen in students' journals and thus happens after, but about an event in the practice setting. A feature of student reflection which may be characteristic of learners in practice, however, is the reflection that happens in what I term, puzzling-the-ought. This reflection is undertaken as part of puzzling out connection and learning the complexity of the practice of nursing. In this type of reflection students seem to be clarifying their thoughts, feelings, beliefs and values. Their conclusions do not necessarily transform their current practice, but are reflection on how and who they are, in response to nursing practice.

I was overwhelmed with mixed feelings of anger and despair. How can a human being be so disrespectful and uncaring towards someone else... I felt really guilty for not intervening but I know that with the amount of anger I was carrying I probably would have acted irrationally and would have said things which I would later have regretted. I just sat there and held the baby close to me perhaps to comfort myself.

Haegert suggests that nurses require a form of moral development to enable them to care. "They need to become fully integrated persons to act wholly according to their intrinsic capacities and ideals of caring" (1999:118).
This 'reflecting-the-ought' indicates a process of making sense of students own ideals and their experience of nursing in the institution. It indicates that students are puzzling, formulating, and crisping their ideals: a form of moral development. This sense of what is best and worst in a given situation is part of developing their awareness and presence in the practice setting.

Current theories and models relevant to learning nursing

The nature of learning that has emerged from this study is about learning in a practice setting in preparation for work as a professional in the practice of nursing. It is thus also a model of learning to care as a professional. It is about learning to do a certain kind of work.

The nature of the work of nursing is therefore a route towards a better understanding of learning the work. The nature of developing nursing expertise, initially described in *Novice to Expert* by Benner (1984) and the subsequent research expanding this understanding, with various nursing scholars including Wrubel (1989), Tanner and Chesla (1996) and Hooper-Kyriakidis and Stannard, (1999) have served as extensive reference in this study thus far. Students in this study do not often experience this kind of expert in their practice and it may therefore be seen to have been a less than useful comparison. I discovered Benner's later work in 1997 and it was their extensive exploration of nursing that enabled me to understand and articulate the nature of nursing better. The work of Benner and her colleagues was not used as the theory base of teaching the students in this study. But by then I was able to recognise that what I was observing students do in learning to nurse children was compatible with their preparation for practice as expert nurses.

The theory/practice gap, between educational goals and experienced reality in nursing, which "...may be a philosophical problem for educators, is a daily irritant and handicap for practising nurses" (Campbell and Jackson, 1992: 476). Clearly, a thorough exploration of the nature of nursing is a way of understanding the reported discrepancies between the practice and theory base of nursing.
Student nurses are reported to describe the theory base of nursing as “inert” (Cope, Cuthbertson and Stoddart, 2000: 854), a descriptor which students in this study may confirm. Melia’s wisdom in undertaking a scholarly exploration of the nature of nursing work (1979) established a basis for her subsequent exploration of how student nurses learn to nurse (1983 and 1984), can certainly be affirmed from my experience of this study.

Campbell and Jackson (1992) link their exploration of the practice and theory of nursing with how conceptualisation can obscure learning the practice of nursing. They make the links between these two aspects which they call “both halves of the nursing reality” (1992: 494). They exhort educators to make sure that the programmes we design “show students how to cope with the practical sense caregiving makes as well as the complicating aspects of conflicting values, staffing limitations and time constraints in the actual practice settings” (1992: 494). Rather than comparing the ‘knowing that’ (the theory base) and the ‘knowing how’ (the actual doing in practice), these authors explore the way that nursing is conceptualised, thought about and practised at the present time. They show how the conscious effort to create a unique and scientific theory base for nursing has delivered frameworks and models, thus creating the authoritative phenomenon of nursing. They argue that while “…nursing models provided a theorised plan for constructing curricula and delivering instruction in an accountable manner, they fix nurse patient relations in time and space so that they can be predicted or reported in accountable ways” (1992:478). The way these plans affect educational programmes is that while they are of use in directing and evaluating learning, they fail to capture the actual activity of practical caregiving.

In this study, much of the learning or puzzling out connection evidenced by students shows their grappling with finding the fit between what they anticipate and know, with that which they find as they encounter children in different situations. This often untidy and complex process is certainly not a linear one of linking theory to practice, but rather one of making sense of the reality by being there. The process of their learning could be understood in the developing interdisciplinary school of thought known as "activity theory".
The work of Vygotsky (1978), a Russian educationalist, is central to the view that actual human activity does not only arise from some kind of pre-existing scheme of meaning but rather as part of a process of practical sense making in the situation. Activity and learning are always conditional and emerge from the situation. Activity is seen as an ongoing purposeful activity, or what Wittgenstein (1958) called "a form of life" (cited by Campbell and Jackson, 1992:482). This approach emphasises the presence of a self-conscious actor who produces the meaning in the course of doing the action. Actions are also located in the context of the cultural and institutional setting.

Campbell and Jackson (1992:483) point out that by placing the action back in a social context, this approach remedies much of how the scientific mode objectifies actions and actors. It also reclaims a place for a knowing, acting person as the necessary center of every activity. The value of this kind of framework is that it affirms both the interpersonal interaction utilised in phenomenology and ethnomethodology - which appreciates the patient as a person and the complexity, cultural and socio-economic aspects, which shape institutional life (1992:483).

'Situated learning' is a school of educational theory, which has also been influenced by among others Vygotsky's work. Cope et al (2000) utilise this theory to explore the nature of student nurse learning in the practice setting. They conclude that the practice placement is a complex social and cognitive experience for student nurses. This concurs with the findings about the nature of learning which have emerged from this study. The importance of acceptance into the community of practice is also confirmed. Cope et al further suggest that this acceptance can be conceptually separated into social and professional acceptance. They contend that this difference is related to the situated nature of the learning. The social acceptance, which may be afforded to any newcomer, is different from the acceptance earned by proving appropriate competence (2000:853). They confirm the assertion of Lave (1988) that a critical part of socialisation into practice is the opportunity to make an "authentic contribution to communal enterprise" (cited by Cope et al 2000: 853). Being given tasks peripheral but authentic to the activity, is therefore considered crucial to successful learning. This has been termed "legitimate peripheral participation" (Lave and Wenger, 1991) and been explored as a strategy for nursing by Spouse (1998).
This study suggests that acceptance into the practice setting relies not only on competence and interpersonal relationships between students and staff, but also on relationships with the peers and the teacher, children and parents. These are also important in this process of acceptance and underpin the significance of interpersonal relationships in learning. Rather than supporting a model in which the ‘community of practice’ is the staff team in a clinical setting, this study proposes a broader community. The term – “community of practice” used by Cope et al, could be modified to become more inclusive, to ‘community of care’. This model would fit comfortably with Palmer’s (1998: 101) concept of “community of truth” in the learning environment. He describes that in the community of truth, “…like in real life, there are no ultimate authorities…[H]ere knowing and teaching and learning look less like General Motors and more like a town meeting, less like a bureaucracy and more like bedlam” (1998:101). These descriptors could easily be recognised in a children’s ward, a play school and sometimes a classroom where various small groups of students are convincing and being convinced. This broader description confirms the complexity of the setting. It may be argued, that if learning nursing is about socialisation into the profession of nursing, acceptance by professionals is most important. This may be so, but the relational complexity of the “town meeting” nature of the clinical setting is the authenticity of the practice in which the student must become familiar and accepted.

This option of an extended ‘community of care’ includes the patients, the children and their parents, as people who contribute to learning and caring in the setting. This broader description enriches the concept of caring and how students learn to care. Nurse educators like Diekelmann(1990:301) use this term to describe the environment we need to create for clinicians, teachers and students in a caring curriculum of nursing. Her conviction is that this kind of community can be created through a different dialogue with the purpose of establishing “a commitment to care and responsibility” in schools of nursing (1990:304). The same term is used here not with the purpose of contrast or comparison but to broaden the concept to actual care settings, and welcoming into the “community” the children, and other people who find themselves in need of care in clinical settings. This study confirms that these are also experts, who do contribute to students learning to nurse in face-to-face encounters.
The nature of learning emerging in this study can be described as involved and relational. Students experience being touched and use a kind of reflecting which is termed 'reflecting-the-ought'. It is contended that learning to care must be situated in authentic communities of care and that everyone in that community can contribute to student learning. In these settings student can learn to get a feel for a form of nursing action that is reasoned, responsive and engaged. In such settings their activities are real and authentic and the learning therefore gives them "...a sense of nursing as a form of life", as proposed by Campbell and Jackson (1992:494).

Why are shifts from the theory to the practice of education difficult?

In the last 15 years there have been many signs of change in nursing education. In the extensive curriculum change in Project 2000 in the UK and in what is termed the curriculum revolution in the USA, models from transforming learning theories have been offered as alternatives (Bevis and Murray, 1990; Diekelmann, 1990; Tanner, 1990; Allan, 1990). Shifts in education, among others the emancipatory pedagogies (Friere, 1988), have influenced how we think about the practice of education. These debates and models provide an opportunity to move beyond the sanctioned behavioural perspective; but the shift is not easy.

Although the UCT curriculum was never called a 'caring curriculum', the tenets underpinning the health-based curriculum with its particular features of commitment to individuals and their development, required similar approaches. The small team of committed teachers has remained almost constant for the last ten years. In this time we have continued to refine the curriculum and to assist one another and the students with the shifts in thinking and approach. Each teacher has a different style and yet the commitment to one another and the approach has resulted in the development of innovative teaching methods. Relational links with a variety of non-traditional health care facilities, from informal settlements and a project for the homeless to a novel neighbourhood style cluster of houses where elders live together, have added much to student learning. Student placements in these areas have been well received and proven to be rich in learning.
The commitment to training teachers for change also led to the design, implementation and evaluation of a non-traditional post-registration programme for nurse teachers (Kyriakos and van den Heever, 1999). Relational patterns are now well established, but still the shift was not easy, for the last 15 years this road less travelled was often been a steep one.

Hartrick (1999:18) describes the difficulty well: exploring the nature of teaching communication in a new paradigm, she acknowledges “...that the map does not necessarily reflect the territory”. Others describe the slow and painful process of the transition to new ways of thinking and new approaches: the uncertainty and the fears as teachers need to relinquish their power and students need to become visible and participatory. It seems that nurse educators are still divided. The debates around objectivist education continue in the form of problem-based and outcomes-based curriculum models. At the same time another dialogue, one of caring, one of partnerships with students, one of authenticity, introduced by authors of the curriculum revolution like Diekelmann, Tanner and Allen, still entices some and elicits scepticism from others. These perspectives may not be mutually exclusive, but do require that we hear one another in the debate.

This discussion of the nature of learning as it emerges from this study would not be complete if it did not answer or at least contribute to the dialogue of shifting towards application in nursing education. This will include relationships in schools of nursing, communities of care and the teachers where this kind of learning can be facilitated.

A Relational Ethic in learning to nurse

The outcomes of this study offer evidence to support the importance of interpersonal relationships in learning to nurse. Although authors like Diekelmann (1990) and others proposed that communities of care be nurtured in schools of nursing in order for caring curricula to be implemented, the reality remains that relationships are difficult to regulate. Liking or getting along with someone, is often not predictable. It seems that rather than trying to define or regulate relationships, the focus should be on creating a relational ethic, on comportment - a stance or way of being with others.
Educationalist, Nel Noddings, who encourages an *ethic of caring* in educational settings, wrote the following:

In the climate of transformation that exists, *(also in South Africa)* in the language of liberal ideology we are witnessing a renewed emphasis on ‘equality’ and ‘diversity’. This may be labelled “good” but we are also seeing a proliferation of bureaucratic regulations and specialised jobs, like ‘ombudsman’ and ‘equity-’ or ‘transformation officer’ *(like currently in South Africa)*, which may be labelled “not so good”. Noddings notes *(and I agree)*, that a liberal counter reform will not transform education, *(our faculty, nursing education, our health services)*. This is because it does not challenge the fundamental premise of masculine intellectualism: which rests in making things abstract and predicting their consequences. To challenge these we need a language of relation that guides our thinking in concrete situations, a language of relationships that can be comfortably used outside the private domain” *(1986: 499)*.

Here again we see a call for approaching what Bowden calls “...that immensely important ethico-social construct, the public/private divide” *(1997:102)*. While the relationships of nurturing and caring can be considered to lie in choice on the one side, the other, the more public realm of obligation governs relationships in the provision of education and nursing.

Human society balances choice and obligation. Pre-industrial societies, for various reasons, tended to impose strong obligations while allowing little choice. In the modern mega-community, obligation has become de-emphasised and choice has become the dominant social value *(Schluter and Lee, 1993:63)*. This might be part of the dilemma we face in nursing education: a struggle with the obligation, which does not seem to welcome choice or offer options of differences in relating. Central to relationships, however, are the two qualities of obligation and commitment. Both of these are born from an underlying ethos, which is philosophical and metaphysical in nature. Schluter suggests that “[a] sense of duty or obligation is determined in part by the individual but in part it is a matter of how we order both public and private life” *(1996:3)*.

While it is clearly not possible to regulate human relationships, Schluter and Lee *(1993)* propose a model of *relational proximity* to guide aspects of relationships in public life. The model is not based in an ideology and underpinned only by a set of presuppositions about the nature of human beings *(1993:267)*. These are that:
• all human life has intrinsic value and dignity
• good interpersonal relationships are of primary importance to both individual and societal well-being
• good relationships depend on the presence of both obligation and choice in the social structure
• a good relationship is to be understood primarily as a morally good relationship

The model of relational proximity proposes to contribute to public life in institutions of learning, by proposing a framework for developing policies and structures. The authors have described five dimensions which, broadly speaking, provide a quantifiable measure of closeness between people. These dimensions describe the "...structure of personal relationships and they (the dimensions) constitute the necessary preconditions for 'empathy' (an understanding of how other people feel and react) even when people do not necessarily like each other" (Schluter, 1996:10). This model is proposed here as a way forward in the structuring of nursing schools and curricula, as these move towards a relational ethic in learning.

Relational Proximity
Directness - the extent to which people meet face to face rather than having contact through a third party or through impersonal media.
Continuity - proximity through time, the extent to which people meet frequently, regularly and over a sustained period of time.
Multiplexity - the extent to which people have contact in more than one role or context, so that they can see how others respond in different situations and can understand other dimensions of another person's background and lifestyle.
Parity - the extent to which people meet as equals, not in terms of role or status, but in terms of their sense of personal worth or value.
Commonality - is proximity of purpose, in which goals and aspirations are shared.

(Schluter and Lee, 1993:269)
Relational Proximity in Schools of Nursing

The relational proximity model has been used as an audit tool in various settings in the UK. The UCT Department of Nursing has not formally implemented this model as a guide to managing and planning academic and administrative activities, it has however been operating on similar principles which will be utilised to indicate the principles.

Schluter and Lee maintain that directness somehow "...saddles you with the awareness of responsibility, just as indirectness somehow lets you off the hook" (1993:77). The value of an awareness of responsibly in learning to nurse is its contribution to relationships within the community of learning. Directness in teacher-learner contact increases the relational possibility between the two and decreases the culture of fear described by Diekelmann (1992) and Palmer (1998). More contact and thus more chance for getting to know the other members in the student’s community of learning allows interpersonal connections in which learning occurs. Without directness in a child nursing curriculum, a child may remain the “pneumonia in the fourth cubicle” or “the C.P. in Prof. Smith's bed”. Policies committed to directness, like the possibility of using the same tea rooms, lifts or passages facilitate people, teachers and students coming into more contact with those usually considered “other”. This regarding of people as “others” is another cause for the fear in educational settings described by Palmer (1998:37). In a relatively small department of 6 faculty to about 100 students like at UCT, directness may be easier to achieve. Like most relational qualities however directness is a stance, a welcome and a willingness to consider a change from the familiar and the comfortable.

It takes time - a certain frequency and regularity of contact - for relationships to develop, as continuity is what “...links time and trust in relationships” (Schluter and Lee, 1993:77.) Continuity is one of the relational qualities, which strengthens our relational base or the network of people in our sphere of activity. In the course of a three to four year nursing programme, there are many events which can shake the student’s relational base. Relational capacity depends on continuity of other relationships in the relational base (Schluter and Lee, 1993:77). But if we encounter a succession of different people, like regular changes in ward placements or tutors or mentors, our sense of solidarity with others and our sense of responsibility for them remains superficial.
Teaching strategies like those of co-operative learning, which encourage the development of learning and student support groups, are an attempt at strengthening this solidarity. If, however, as this study contends, students learn in relationship with not only one another but also the teacher and others in clinical practice the factor of continuity in these relationships needs to be fostered with greater commitment.

A commitment by faculty to multiplexity or contact in more than one role or context, allows students and teachers to see how people respond in different situations. This aspect of relational proximity is particularly important for nurses and teachers who often engage others in a role based model. For nurses it may be ‘nurse and patient’ or ‘carer and dependant’. I have asked a mother assisted by her three year-old to lead the discussion about children with special needs, or invited a group of seven-to ten-year olds to participate in a classroom session exploring how we communicate with children. Here the children evaluate the students! In these settings usual recipients of care become the experts. Certain roles are familiar in teaching; the ‘knowledgeable and the ignorant’; ‘marker and the assessed’. The challenge to teachers by Palmer (1983) to “…be known as [they] are known”, is one that exhorts teachers to allow themselves to be seen and known by their students. He maintains that in this, teachers are more likely to be able to “…create a space in which an obedience to truth is practised” (1983:69). This contributes to the authenticity nurse scholars and students call for and seek as the ideal.

Schluter and Lee maintain that “role based relationships in the modern mega-community are often one dimensional and that only the opportunity of observing one another in different roles and relationships allows opportunity to truly understand one another” (1993:80). We included student representatives on some governance and planning committees like the curriculum planning. This allowed us to see one another’s styles and strengths in different roles. Social events like a whole department dance or fun run also help us to understand other dimensions of one another’s background and lifestyle. These events afford opportunities for relationships to become established and can strengthen teacher and student relational capacity.
As people meet in different roles the concept of parity, means that people meet as equals, rather than in terms of role or status. This does not mean negating roles or expertise, but merely that these are not the context or parameters for interpersonal relationships. This is probably the most challenging aspect of this model to consider in an educational setting. Research has evidenced that it is a challenge in health care settings in the National Health Service in the UK (Jubilee Centre, 1998:47). In the relational proximity model, parity means meeting on equal terms based on people's sense of personal worth or value rather than the power of their position. "Parity is important in relationship because large power differentials frequently lead to abuse" (Schluter and Lee, 1993:83). These authors suggest that power affords people freedom and that "[w]e value our freedom too much to take equality undiluted" (1993:83). They maintain however that a commitment to parity shortens relational distance by establishing proximity in levels of power, thus allowing people to cultivate common ground (1993:85). This is a quality of relational proximity we could well explore in schools of nursing.

The last aspect of proximity, commonality, exerts a powerful influence on social behaviour. Commonality is the extent to which people have common purpose and common experience, factors which help to cement and deepen relationships. In a school of nursing this means that students and staff and ideally the school's clinical partners benefit from sharing a common vision. This implies having a philosophical base and ways of nursing that people know, believe and can articulate. This ideal is embodied in the notion of "communities of care" described by Diekelmann (1990) and other authors writing about the curriculum revolution.

There is the very real concern that relational proximity can place us too close to one another for comfort: not a place conducive to relationships. Therefore, relational proximity is a necessary but not sufficient condition of good relating. Human beings need to be brought close enough to make relationship possible, not be crushed together. Schluter and Lee contend that relational proximity provides "the potential to interact" (1993:90). It is offered here as an option to consider how practically to work out a relational ethic in learning to nurse. While it enables people to meet their relational needs, it does not in itself embody the obligation or morality that is central to a definition of a good relationship. Nor does it account for our willingness or personal commitment to fulfil the obligations inherent in relationships.
Schluter and Lee offer the model: "...to keep in good order the relationships by which obligations and commitment are cultivated, as midwife not a mother" (1993: 90).

Earlier I quoted Noddings as saying that the "...fundamental premise of masculine intellectualism" (1986:499) had to be challenged. I think that there is more to challenge. It is interesting that the model of relational proximity was developed shortly after Noddings wrote this. Its designers, Schluter and Lee (both men), an economist and a scholar of theology, were equally aware of the current failings of a liberal ideology. Their impetus was a search for the Biblical foundations for order and prosperity in public life. Concluding that relationships are the links that hold society together, they maintain that it is only "through the creation of relational markets and democracies, that people will find personal fulfilment and build a truly stable global order" (Schluter and Lee, 1993).

This model of relational proximity has been implemented with success over the last three to five years in various institutional settings in the United Kingdom. To this end the Relationships Foundation based in Cambridge, have used a relational audit in legal firms, commercial enterprises, prisons and health care settings. The model offers an approach that can be explored and implemented at an institutional level, and while this could assist teachers with the development of communities, it is evident that there is another level of relationship, which requires exploration.

Communities of care in learning to nurse

Humanistic thinking has contributed considerably to the evolving and expanding Theory base of nursing. It has helped to shift thinking from mechanistic to more human person-appropriate ways of thinking. The common humanist hypothesis about the human condition is a certainty about the innate goodness and wisdom of man (Packer and Howard, 1985:19). In much of the nursing literature, an innate belief in each person's capacity to care is also evident. I want to honour these scholars for their determination and rigour in conceptualising and propelling the discipline of nursing. While I believe in the value and uniqueness of each person, there is much evidence as we enter the 21st Century, of people's intention to do harm. Wars and crime and abuse and greed and
apparently conscienceless corruption are not only the focus of reported news, but reality in the lives of many people.

I am not sure how many students arriving in schools of nursing have memories or experiences of being nurtured and cared for. In my recent experience the number is fewer and fewer. At the UCT Department, we believe like Noddings (1988) and Cohen (1990: 621) that "...caring has to be experienced to be known" - an understanding that learning to care comes from being cared for. This study has shown that students' resources influence their learning, not only their perception but also their access to resources. Resources are nurtured by learning: not only by the acquisition of knowledge but by being heard and by listening. The evidence that students learn in the context of complex webs of relationships has led to the proposal of a broadened concept of "communities of caring". Crabb suggests: "The central task of community is to create a place safe enough for the walls to be torn down, safe enough for each of us to own and reveal our brokeness. Only then can the power of connecting do its job. Only then can community be used by God to restore our souls" (1999:11).

Most authors may not have this kind of community in mind when they describe community as an ideal. Despite lofty descriptions of community, most of their experiences of community may be more like mine, so well described by Crabb: "We arrange our bodies in a circle, but our souls are sitting in straight back chairs facing away from others - we all play it safe, because none of us feels safe in the group- not really" (1999:xiii). Crabb, like Palmer (1983 and 1998), "insists on embracing the formidable difficulties involved in community: there are no shortcuts; there is no avoiding confusion and disappointment" (Peterson, in Crabb 1999: vii). Confusion and disappointment have certainly been my experience of this difficult process. Much as I yearn for and begin to experience a kind of caring community in teaching, it is not one to which I would aspire without my awakening but strong sense of the grace of God. I have seen change happen where souls meet or as Crabb suggests where our souls face each other (1999: xii).

The failure of human ideologies to provide this kind of context of relationships makes the underpinnings of the relational proximity model so much more accessible. As Schluter and Lee (1993:270) describe it: "All four [of] these propositions could be discerned as intuitively self-evident, or rationalised on a purely secularist basis of
utilitarian humanism. None of them demands a metaphysic, but at the same time it is easy to see how they can be integrated with the perspective of faith. Relationalism with its emphasis on social and personal values in ordering of public life distils out an ethic upon which humanist and theist, Hindu and Muslim, Christian and Jew can all agree. It could be a basis on which institutional policy is made (in the public realm), but nevertheless the pressure to create a relational ethos must come from the people who live and work there. It begins with an innermost conviction of how human life should be lived and thus stems from the private realm.

In learning to nurse it may be that looking at the capacity to participate in human community is the key (Gunderson 1997:7). This author maintains that health is inherently communal, an understanding that is easily accessible in an African paradigm. He proposes that “[w]hat most humans actually know is that we are here briefly and die, and in between the only thing that matters is giving and receiving love among other humans. The primary gift of spiritual life is not knowledge of ones own private functioning. The great power comes from a sense of finding ones place in the universe and finding that the place is a gift of a gracious God” (Gunderson, 1997:9). This perspective is one quite different from the dominant one of humanism, but certainly one that has enabled me to put all things private in a different perspective. I would agree with Peterson that these perspectives of community are “…a welcome (and authentic) contrast to the prevailing entrepreneurial spirit of the age that turns community into a commodity” (in Crabb, 1999:viii).

The “who” and “how” of the teacher.

“… [G]ood teaching requires that we understand the inner sources of both the intent and the act.” (Palmer 1998:6)

The nature of teaching as it emerges from this study, is walking alongside. A complete picture of the nature of teaching was not the purpose of this study, yet this awareness of walking alongside has become evident in both what the teacher did and what she did not do (in the role of observer). It may also be that the acute awareness created by watching students and their interactions could not have yielded anything different from the awareness of walking alongside.
Noddings (1988) maintains that the primary aim of education is to nurture the ethical ideal, which is a caring ethic in teaching. This means that the "guiding principle is our primary concern for those whom we teach" (1986:497). There is an interesting balance (or counterbalance) in the British approach and literature. Cahill (1996:792) described the approach to mentorship "in contrast to all this emotion and intensity [of that in the USA] the systems of mentorship in this country appear to have adopted a more pragmatic approach". Another British author, Burnard (1990), suggests that a formalised mentor or means of support may do more to foster conformity than to encourage independent thought and professional growth. He holds that a view of a kindly, experienced support person does not fit comfortably with the principles of adult learning. Students in Cahill's study (1996) like students in a similar USA study (Hanson and Smith, 1996), were able to describe good and bad mentors. But their experiences of mentors were "non events". They seemed unaware of mentors except that they were there to write a report (1996:795).

In the experience of this study, focussing or committing to a relational ethic enables the teacher to come alongside more legitimately. Teaching and learning are more integrated and one can manage the power issues as students can find voice. If inequality exists it is difficult for learning to happen, this is confirmed by Cahill (1996:798). Cahill's research indicates the continued focus on assessment that Diekelmann (1992) calls teaching-as-testing. The hope that supernumerary status would solve some of difficulties surrounding mentors, during the shift to a new policy (UK) namely project 2000 seem to have been unmet as Cahill's and other studies concludes that in their research settings mentoring is almost synonymous with supervisor. A relational ethic may go some way to remedy these relational difficulties.

Parker Palmer directs us back to the private/public debate with this statement: "...Unlike other professions teaching is done at the dangerous intersection of personal and public life" (1998:17). He contends we often try to reduce our vulnerability by disconnecting from our students, our subject, and from ourselves. Maybe we build walls between our inner truth and our outer performance and play act the teacher part as we sometimes play act the nurse part. Palmer suggests that that distance makes life more dangerous still by isolating the self (1998:17). It is probably in this "dangerous intersection" that our relationships become most invisible.
This is especially likely in the space and pressure of reforming curricula, increasing research output and publishing in which many nurse teachers find themselves. Administrative issues in higher education settings and student interaction and evaluation increase burdens further at a time when many nurse teachers are struggling to simply survive and it may sound indulgent to spend precious time on issues like truth and the quality of selfhood or relationships.

But Palmer argues that he calls the teacher's "inner landscape" is important. He maintains that this landscape has three paths:

- The intellectual path is the way we think about teaching and learning, the form and content of the concepts of how people know and learn the nature of our subjects and our students.
- The emotional path is the way we and our students feel when we teach and learn, feelings can either enlarge or diminish the exchange between us.
- The spiritual path is the diverse ways we answer the heart's longing to be connected with the largeness of life. A longing that connects love and work, especially the work we call teaching. (Palmer, 1998:7)

My experience of teaching would confirm Palmer's assertion that none of these aspects can be ignored. "Reduce teaching to intellect and it becomes a cold abstraction; reduce it to emotions and it becomes narcissistic; reduce it to spiritual and it loses its anchor in the world." Palmer maintains these three pathways depend on one another for wholeness. "[T]hey are interwoven in the human self and in education at its best " (1998:4).

The Hebrew word for teaching and learning is the same: 'lamad'. This word has as its root the idea that a teacher has not taught unless a student has learned (Virkler, 1991:5). The Germanic root of the word 'teacher' - 'tecan', essentially means to show. This action probably best occurs when one is present with students. Various studies that have explored the nature of student-learner relationships have described the importance of this presence, both from the learner and the teacher's perspective. Of course, learning alongside others is centuries old, but in the current climate of the information revolution, teachers' roles are changing. I would like to make a case for the relational role of teachers. It is a role we need to refine rather than discard under the pressures of distance and peer learning, but more importantly, we need to keep a close check on our inner landscapes and how we work these out in supportive relationships.
CHAPTER 8

Implications of the study
"...and now as I look back, I feel as though I have traveled a long road!
From wanting to walk out that door to wanting to walk in..
"

From a student journal after leaving her last children's ward

This last chapter concludes this inquiry with the implications for nursing education, for nursing practice and theory development as well as research recommendations. Some of these implications could contribute nationally as South Africans move towards establishing a relational ethos in a fledgling democracy, especially a different ethos for learning. A recently established National Qualifications Framework requires changes to all the county's established educational structures. Tertiary institutions offering programmes for health care professionals are exploring the possibilities of curricular shifts as the methodology of Outcomes Based Education has been accepted as a national curriculum model for primary, secondary and tertiary education settings.

This interpretation of student learning informs the body of knowledge in nursing, by adding to our understanding of learning and considerably broadening the intellectual or cognitive models of learning. I believe that it establishes a base on which nurse educators can better understand and build interpersonal relational models of learning. It offers a description and analysis of the interactive nature of learning in a practical setting and should therefore contribute to understanding as well as practice. Although not the intention of the study, it has validated the outcome of the curriculum and the diverse and relational methods developed by teachers at the UCT Nursing Department.

This chapter will consist of the following sections;

- Implications for nursing education
- Implications for nursing practice
- Implications for theory of nursing and theory development
- Limitations
- Recommendations for further research.
1. Implications for nursing education

The major educational value of this study is that it translates the broader philosophical notions of learning to nurse into more concrete notions of practice. It contributes the experiential perspective of students learning in the context of interpersonal relationships and learning in an often not ideal practice environment.

This study proposes that the way students choose to learn is in the context of interpersonal relationships with children and not something, which they need to be taught to do. Their learning requires facilitation of relationships rather than only the more traditional 'accompaniment' model usually utilised by teachers to monitor and evaluate the acquisition of skills. This facilitation of relationships with children and their parents contributes to the learning experience of both the student and the teacher.

In the introduction to this study I referred to the inadequate attention to nursing children in most pre-registration programmes in South Africa. This could infer a plea for increased child-related content in curricula in this country. Additional content is always a difficult issue to consider and the question “at the expense of what?” is inevitable. Rather than focussing on content per se, this study could more easily advocate for a different curricular approach. Such an approach would be committed to recognising the students’ life and relational experience. One committed to facilitating the acquisition of nursing knowledge and skills in the context of students’ own resources and relational skills. The basic curricular tenets at UCT of a lifespan approach to learning and health-based perspective allows students to gain a family and community perspective, while building on specific nursing skills as they adapt their approach to the different people they encounter in their practice. A relational ethic in the school of nursing facilitates students’ learning ‘skills of involvement’ as they encounter people, irrespective of age, gender or other characteristics.
A further contribution is that this study has described student learning in a third world setting. In these settings the notion of "developing" and "under-resourced" have often thoroughly underestimated the resources of the people and their way of inhabiting the places in which they live and learn. In the bid to keep up with western counterparts, services and practitioners alike have worked hard at measurable outcomes, usually objective in nature. The value, ethic and nature of care in these circumstances have often been lost. This study contributes to the educational practice base and understanding of learning in settings where the transition from objective problem solving to interpersonal caring as the base of nursing is only beginning to occur.

Educational programs in Nursing can accelerate this change by recognising and facilitating students' specific expressions of caring and learning in relationship. Articulating and valuing what each student and each teacher and each child and family brings with him or her would contribute resources to the pervading 'scarcity' perspective. In a society where diversity is often seen as a plague rather than a blessing these resources will only be recognised when we also recognise the values and beliefs each carries.

Merely encouraging or teaching students not to be judgmental will not eliminate their moral differences or help them to understand people. Educational settings therefore need to espouse 'value clarification' as fundamental - in fact as a basic tenet of curricula. Students need to be assisted to see how they think and what they feel so that they enter relationships with others with some understanding of their own responses. They need to ask questions like: Do I like children? What do I think about mothers and their responsibility? How do I feel about taking responsibility? Issues like: discipline and punishment, social crimes and injustices, death and dying - all carry private meanings which can be confronted in the relatively safe place of the classroom. In a society challenged by AIDS, moral decisions seem even more complex and students need to know what they think and feel about who receives treatment and from whom it is withheld. Students who are in relationship with families learn from them and as they encounter differences their respect grows with an understanding of individual's differences.
Class discussions need to start with students bringing what they experience and feel so that theory links with their context and starts to be embodied in their practice. Although they may come with no or little previous work experience, their current clinical experiences bring a rich context for theoretical input. Reflective learning from journals can be guided with care. Some days just writing what happened may be fine. On others their held beliefs could be challenged a little more, encouraging reflection and exploration.

This study supports the value of a shift away from the idea of teaching from a purely objective stance which does not support relationships, involvement, connecting or engaging. Benner (1984) maintains that the essence of nursing practice does not lend itself to detached observation. Learning about distanced objects keeps the femur in the anatomy laboratory and thus it is a femur in traction rather than an active six year old, traumatised by pain and immobility. The shift can be facilitated in a variety of ways. There are many teaching methods described in the literature and practiced from which we can glean, methods that allow the subjective inner world of the student and their experiences to be revealed. Designing curricula and teaching with a relational ethic which support the significance of interpersonal relationships will advance caring within nursing.

Central to this discussion are the teachers and the need to recognise that they too are human. Teachers may need to be not only allowed, but encouraged to engage their subject and the students. We may need to let go of the relational safety nets, which may be more inclined to power and control than to connecting. In this regard, we as nurse teachers may need to reconsider our practice and our often over-riding roles of ‘testers’ and ‘evaluators’. Nurse teachers like all good teachers must have lived their subject before teaching it. Virkler (1991:1) contends that the teacher must: “...have had a personal encounter with the truth he [she] is passing on and be able to flesh them out in his [her] own personal life”. If the truth we are trying to pass on in schools of nursing is ‘care in interpersonal relationships with people’, the teacher too must experience care and being cared for. This may sound simple, even ‘soft’, but I am convinced that this is a fundamental principle. In educational settings we may need a loosening up, not a letting go, of rigid controls in curricula. We may need to place more emphasis on ‘who’ teaches rather than only on ‘what’ is taught and ‘how this will happen’.
In 1993 Burns concluded from her study that the greatest need for change in nursing education is surely espoused in the statement: "they taught us not to become personally involved" (1994,147), this remains so. Professional distance does not sanction connecting. A different relationship between teachers and nurse learners carries a dual reward. The reciprocity means that it is mutually rewarding and it is evident that there is an increased application to practice. The effect of this on learning is significant. It does however require that teachers be willing to let go the ‘what is covered’ as we look for ‘what is known’ and ‘what is learned’. The broadened understanding of the way people reach knowing is explored in this study. It suggests that participation with our whole being, our entire self- increases our knowing or knowledge. Shifting the focus of curriculum models, to caring in interpersonal relationships, may start to recognise more of the learning that students do. The ways of knowing that occur often outside the classroom would gain respect, as we notice what students notice, how they use intuition, seek to understand, work out what to trust, this is learning nursing.

2. Implications for nursing practice.

Hospitals in South Africa are currently driven by cost containment pressures, experienced primarily in staff cut backs. In private hospitals nurses are encouraged to keep up the bed occupancy rate while in public hospitals there may be mothers sleeping upright in hard-back chairs, due to a shortage of space. A medical superintendent, although supported by a nursing deputy director and a nursing management team, mostly manages hospital services. In hospital settings decisions about care are vested primarily in the medical personnel. In settings other than hospitals, registered nurses may direct care but are often occupied with administrative tasks and even here seem more likely to be supervising than delivering direct nursing care. It seems that in these contexts, many people including nurses themselves are sometimes uncertain of what nursing is. Many seem unaware of the breadth of the practice or the value of the rich theory base of the well established discipline of nursing and how much these could facilitate nursing children and their families.
Although this study has yielded a model for student nurse learning there are implications which can be inferred to the practice of nursing. The most specific is the current nature of registered nurses’ work. Students describe their “missing” the registered nurse in settings where they need to make decisions about the care of children. Students then do not experience the implementation of well-reasoned care. Students by their very nature want to be involved with the process, discuss the implications of a certain decision for a particular child. This lack of involvement by registered nurses may be partly due to their not understanding the theory base of the discipline of nursing. Nursing models and theories of nursing not being prerequisite in the preparation of registered nurses in this country (Kyriacos, 1992), does not help this dilemma. The models of systematic objective problem solving rather than the more interpersonal caring models of nursing pervade care settings.

The registered nurse’s relative absence from the child’s bedside means that the sanctioned public ways of relating espoused by nursing are often not modelled for students. Their models are more often the private patterns of the auxiliary* and enrolled* nurses, undefined by nursing knowledge or theory. These nurses do not have the benefit of a broad theoretical base and understandably their knowledge of the growth and developmental of children is gleaned only in their experience of children and of nursing ill children. This makes it difficult to apply age appropriate suggestions and actions. Communicating with children is also more complex than mere language and interpretation skills. In paediatric practice settings it seems imperative that all nurses are trained to recognise and respond to children’s expressions of fear and betrayal and to hear their asking for truth and protection.

The specific context of relationships with children highlights the challenge which is central to the practice of nursing children. Working with mothers and families is about establishing different teams: it is about developing family and community partnerships. This is not an easy task but the shift in South African health provision policy requires that all nurses especially children’s nurses will need to make this shift.
Burns (1993) describes registered nurses lived experience of engagement with children and their parents. She calls the process: creating safe passage. This is the practice of the registered nurse and it follows that learning to connect, especially in relay with the child’s mother, is the precursor of this for students. The ideal would be that in the clinical learning setting, the student is in relay with the mother and the expert nurse.

An aspect that student data describes well is the stress of working with sick children. Some of these like inflicting pain to heal and making sense of a child dying are well described by students. Unlike adults who are more likely to be part of the process of treatment and care and therefore submit to being hurt, children do not. Nurses who have worked in the same settings with children for a long time, often do not express the experience as vividly, but I doubt that they are completely unaffected especially by their participation. The clear emergence of the importance of others present and resources in this study adds to the copious evidence of the importance of support in clinical settings. In most busy clinical settings mechanisms of support have to be set up, and constraints of time need to be lifted to facilitate staff eliciting support from one another and offering them the opportunity to de-brief.

Burns (1993) concluded that the environment and nurses own thoughts, feelings and perceptions influence their engaging. This sounds like a description of the resources in this study. Confirmation of the importance of resources in coping and caring imply that it is very important that nurse managers and clinicians implement strategies for staff support, which best suit their units. “The practice of nursing is living out the art of caring through nurse patient relationship” (Burns 1993, 133) - this beautiful description or definition certainly helps one to understand what students are trying to learn and what clinical nurses should be assisted to recognise and live out in their practice.

Somewhere in the complexity of what we call nursing children, students must find their place. As they puzzle out how to connect with children they find the essence of nursing: being with someone, bearing witness to someone’s health (Parse, 1992). Learning like this in relationships with children teaches them that nurses provide care in the midst of people’s health, pain, loss, fear, disfigurement, death, grieving, challenge, growth, birth and transition on an intimate front-line basis (Benner & Wrubel, 1989:xii).
Learning to care like this helps students to learn that theirs cannot be a romanticised or trivialised view of helping others. The pain and difficulty are too acutely experienced, in it they start to taste the challenge and the victory expert nurses describe as they meet difficulties with the intention of caring.

Walker & Redman (1999) make a strong case for restructuring nursing curricula to respond to the needs of the consumer and the market. Students in this study are being prepared for a shift in health service delivery, which has not yet happened. Prepared for the needs of the consumer and the market but not yet the espoused needs of the current health provision services. It may be that nurse educators could facilitate the changes required, but clinical nurses also need to be involved. The participatory research methods, especially those of action research may be a useful method to initiate and track the shifts in thought and practice. Here nurse researchers could contribute by entering a partnership with clinical nurses in the research. Walker and Redmond (1990:300) suggest that we “…bring forward the strengths of our past and discard the routines in practice, education and research that have not served us well. These authors plead that we give voice and decision making to people we serve in both health care and education, “…while retaining the strength of our roots in which a nursing praxis of which laws of health, nursing, educational inquiry, and philosophical and religious beliefs are incorporated” (1999:302).

3. Implications for nursing theory and theory development

Recent writing by Fawcett (1999) indicates the imperative that nursing research be undertaken within nursing paradigms using nursing theories and methods and therefore generating nursing knowledge. I often had to ask myself whether I was working in the field of education or nursing. Whether using a sociologically designed research model detracted from the contribution of the work to nursing? I find myself wanting to swing these questions around. So I ask: How has my knowledge base of nursing contributed to my understanding of the theories and models of education I have visited along my journey of discovery?
I started this research journey with a philosophical and theory base, soundly grounded in nursing - both the practice and teaching of the discipline. My interest in the discipline and theories of education was only beginning. The route to understanding a little more in order to teach a little better was with the destination of better nursing practice clearly before me. The rigor of the sociological method of grounded theory, born from the early flirtations between the "soft" and "hard" sciences attracted me. It has helped me to remain humble about that which I do not understand. The road has lead me to understand better not only how students learn and how to teach differently but as I analysed the data and read more widely, also to a new understanding of the nature of nursing.

The model that has emerged from this endeavour is a model of learning in interpersonal relationships. Not a cognitive learning model but a relational model of learning to care, which has arisen from the use of a sociological theoretical base and methodology, a theory base which holds that human beings interact by ascribing meanings to their context. Does using another human sciences theory base detract from the study as a nursing study? I ask myself. I have concluded that in this study it has not. I would contend that it enhanced this study. A relational basis is so fundamental to nursing that relationship between human beings is the very context of receiving and giving care. The use of a sociological method has therefore been utilised to explore a nursing education theory base. The question then must be whether the theory base of learning the discipline is by implication grounded in the understanding of human relationships?

Chinn and Jacobs define nursing as a "helping discipline with a primary focus on interactions occurring between nurse and client" (1984:41). While theories of nursing differ, there is almost always recognition of interpersonal relationships in varying forms. In some theories the interpersonal process rests on the traits and will of the recipient and the art rests on the nurse's enabling characteristics and the patient's changed behaviour. In others, the interpersonal process is shared or initiated by the nurse, so nursing rests primarily on the nurse's initiative, knowledge and active approaches. Philosophically, this interaction is fundamental to all patterns of nursing however it is qualified. Developments and additions can be traced in subsequent nursing theories, through nursing as an interpersonal process, to the emergence of caring as a concept in the mid-1970's.
Later in the descriptions of the actual practice of nurses, Patricia Benner and her colleagues, further qualify the interpersonal relationships between nurses and their clients as needing to be engaged, thus facilitating nursing as “a form of engaged moral reasoning” (1996:326).

It was not only the relational basis of nursing theories but also the philosophical component of the understanding of individuals, the people with whom nurses work and who nurses are, that enriched my approach to this study and imbued the findings. Early in the process of this research I had a useful conversation with a professor of education. I was trying to understand the theoretical basis of learning. My background in psychology and therefore my understanding at that point was that learning had a cognitive theory base. He listened carefully as I explained the constraints of this limited theory base. I related it to my theory base that defines individuals as whole persons. Mine was a philosophical base not congruent with the reductionist understanding of people having separate parts, thinking, feeling and doing parts. Although describing parts may be useful to theoretically articulate function and articulate being, the whole is much greater than the sum of the parts. I was struggling with how and what were to be my ‘measures of learning’ within this understanding. He nodded and reassured me that I was starting with a broad basis of understanding of learners. He advised that I not discard or lose that at the expense of measurement.

I therefore approached this study, about learning, from a thoroughly nursing basis and it is from within this understanding that this model has evolved. My understanding of learning and teaching has evolved through observation from this perspective. The resultant model has been confirmed by verification in the process and by dialogue with various texts of educationalists, both teachers of nursing and other teachers. The previous two chapters contain much of the dialogue with the written work in the area.

**Contribution to Theory**

Qualitative methods such as grounded theory, have initiated new ways of generating theory. The model of student learning which has evolved from this inquiry indicates that as students learn to nurse children their central process is working out how to connect with the child. The student’s resources and whether she likes children are contextual to her reasoning.
This context is complemented and often complicated by the child, the severity of the illness, as well as the presence of a mother. There are two key influencing factors in how the student reasons or puzzles her interaction and these are her ‘remembering’ and the ‘presence of others’ in the learning setting. How the student understands her responsibility and the ‘knowing’ she has in the situation are the conditions which cause her to act in one of four ways. These four modes of interaction are not dependent on the students increasing competence and it is evident that the same student sometimes uses different modes of interacting at different times. It is however clear that each encounter with a child contributes to her learning and affects how she will connect on the next occasion.

The findings of this study support that involved learning engages the whole of the student, allowing them to know more fully. Burns (1993:154) describes nursing as the "professionalisation of caring through the acquisition and application of knowledge, attitudes and skill". This study contributes to understanding how this “acquisition” occurs and how students work at the application thereof. Not by combining bits of theoretical information, but by becoming involved with actual children. This study is able to further contribute to the development of theories about how nurses learn to nurse. The study is congruent with work done in the last decade involving the epistemology of nursing from an objective to a more caring ethic. The theoretical basis of learning to care is a developing one. This work is congruent with work by Beck and others in the area.

It contributes to the understanding of adolescents as learners, harnessing rather than ignoring students' qualitative attributes: strengths, energies and unfolding experience of this age group of young people. The nature of their learning is not completely synonymous with adult learners as the practice in which they enter is as yet unfamiliar territory. The awakening understanding of learning to care, of relationships between students and children as well as the students developmental stage contribute to teachers trying new methods. This study looks at what students do and has resulted in seeing that they are very active, motivated and committed to children really getting better or at least having a better experience of being ill. The question I asked as a teacher: “How do students learn?”, is answered as follows in this study: Students want to connect. A connected relationship constitutes the context of their nursing and caring. Therefore learning to connect is surely the basis of learning to nurse.
Limitations of the study

This study was undertaken within a school of nursing, with a well-established health-based curriculum. The limitations of my study in this regard are twofold: Firstly, that the setting is an unusual one in this region and this country. The second relates to the nature of the curriculum in which there is an established commitment to the development of interpersonal skills and an often articulated belief that nursing occurs in the context of relationships with people. These could be considered to limit the findings of this study to this setting, even that these could have predicted the outcomes. The purpose of the work was not to generate a theory that could be generalised but rather a substantive theory, the concepts of which could at best be recognised by others and with a possibility of transferability. The reader will need to gauge this, along with the validity of the work.

The fact that the researcher was also the teacher may have elicited data, in their writing and in their conversations with me, that students thought I wanted to hear. My impression was, however that the sheer magnitude of coping quickly in complex and real settings, where the constant presence of a registered nurse was the exception rather than the norm, yielded much honest data.

Another limitation could be the attempt at a grounded theory study without a constant and available mentor in the application thereof, especially by a researcher who was new to the methodology. This may be a limitation but the application will again have to be gauged by the reader. In choosing and being guided by this methodology, I may also have underestimated the researcher’s power. This is particularly possible in the context of what I would term ‘good’ relationships between faculty staff and the student participants. Although I may have meticulously planned the procedures of research and teaching, this distinction may not have been as clear for students. Although a real attempt was made regarding issues of power not only between teacher and students but also between researcher and researched, this may be something which involvement hid from my awareness. It does pose the question of whether this kind of research could be done differently in a truly participative manner as that described in the emancipatory paradigm and this may be a way of testing the model.
Recommendations for further research

- This model of learning to nurse would require testing and, as indicated, participatory action research may be a good methodology to use.
- The question of how we can “measure” relationships or student’s acquisition of ‘skills of involvement’ does require further research.
- It would be particularly useful to observe whether students who learn in traditional nursing curricula also learn to nurse children by puzzling out a connection.
- The nature of student’s resources, not only in their coping, but as key in their learning is certainly worth exploring. This would require consideration of whether student resources are broader than those described in this study.
- Further research could also elucidate ways of building upon these resources with the essential element that resources depend on the students’ awareness and ability to harness them. This applies not only to resources of self but also to the resource of the students’ knowledge base.
- The findings indicate that further research surrounding the nature and particular attributes that adolescent learners bring to tertiary health care settings is required.
- The Relational proximity audit tool has been utilised to raise awareness of the nature of relationships in institutional settings. It may be that the use of this as a research tool could facilitate a shift in essentially content-based curricula towards relational/process/principle-based models.
- Another recommendation is the application of the Relationships Foundation’s audit tool in a participatory research manner to gauge and enhance relational proximity in schools of nursing. This could also be applied to clinical paediatric settings, hospital and other: as has been done with success in homes for the elderly in the UK.
Conclusion:

In the last five years South African economic and restorative policies have brought many changes in health care provision. The philosophical base of primary health care underpins the new structures, yet bureaucratic hierarchies still pervade the health service. The implications of societal change and ingrained institutional patterns continue to challenge nursing and require major shifts in its practice and essentially influence the practice and learning of student nurses. This inquiry was undertaken to understand better how students learned to nurse children in this setting.

This study purposes to understand what student nurses do as they learn in a health-based nursing curriculum. The question was not how they experience children or caring for them but rather how they go about working out the what and the how of nursing these little ones. It is clear that this question is central to the question of how students learn to nurse.

The research question - What do students do as they learn to nurse children - has allowed the researcher to watch and track the process carefully. The data is mostly their own words and thoughts, augmented by those of the researcher as teacher. In their words and thoughts, I trust that you too have heard some of their exhilaration, as well as noticed their fatigue in caring and the burden of responsibility. Students' courage and energy remain my overriding impressions of the data and analysis. The exploration of what they do as they learn to nurse children offers a richer understanding of the theoretical underpinnings of learning about caring, about illness and about getting better in childhood.

The central process which emerges from this study, puzzling out connection, is in essence about the hard thought required by students to work out how they can connect with the children they encounter and the conditions that influence this puzzling out for them. The complexity of connecting with children while learning with them becomes evident through this study. Connecting is what we all do when we meet a stranger, but for students, how they connect is the central thrust of how they make sense of the situation and reason through the application of their emerging knowledge base.
It is in the relationship with the child that the student sees what nursing work is: it is only in being with real children that she can work out the how to do.

Students in this study are also in a life phase of late adolescence and this impacts significantly on how they learn. Their life experience can be brought to bear richly in their learning, they do, however, not have the work experience to enable them to direct their own learning meaningfully and without mentoring. Students' life and relational experience enhances this learning process. Each student's experience and therefore, her resource base, is different. The extent and nature of the student's resources at the time of the experience rather than the experience itself, is the context of her learning. This means that the teacher's most important work is to assist students to build their resources. These include not only building their knowing, but more importantly helping students to recognise their resources of hope and an empathy and to encourage their sense of inner strength and growing confidence. How a student perceives her resource base is the most important contributor to her engaging children and learning.

The four modes students use to engage children are not sequentially learned and once one is mastered this does not mean that another will not be used as the next situation demands. This study has confirmed that there is no set way to approach or nurse a particular child. Each particular situation requires a particular response from a particular nurse or student. Connecting with a child may either leave the student with a sense of hopelessness or it may strengthen her resolve to engage with another child. While learning to nurse children, students bring their private relational skills to their learning of the more sanctioned and public relationships of nursing.

This study confirms many aspects of recent thinking in which shifts in perspectives and practice are occurring and being welcomed. When nursing a child, the student's motivation is how to connect with the child rather than how to do the task allocated. Her focus shifts from doing the skill to relating to the child, by either playing with or guarding the child or coming alongside the mother.
In this study, students expect the teacher to come alongside them as they learn in the challenging situations of real encounters with children. The teacher helps them to make sense of their learning and makes space for them to learn in different relationships. This contributes to the student’s knowledge and replenishes her resources while also placing her in a relational web of people in the place where she works and learns.

The question remains: can one teach someone the relational skills of nursing care? Does it have to do with curriculum content or comportment? Is it not a way of 'being with', of receiving and welcoming. I suggest that a relational ethic guided by relational proximity is a way of coming closer to the ideals which nursing embodies.
Glossary

Anencephaly: Congenital defective development of the brain, with absence of the bones of the cranial vault and absent or rudimentary cerebral and cerebellar hemispheres, brainstem, and basal ganglia.

Enrolled Nursing Auxiliary - Nurses with a minimum of one year of SANC approved training. Called ‘nurse’ on the wards. Constitute 28.75% of all nurses in SA.

Candidiasis: Infection with, or disease caused by, Candida albicans. This disease usually results from debilitation (as in immunosuppression and especially AIDS), physiologic change, prolonged administration of antibiotics, and barrier breakage.

Cardiac failure: Condition resulting from inability of the heart to pump sufficient blood to meet the needs of the body.

Dysentry: A disease marked by frequent watery stools, often with blood and mucus, and characterised clinically by pain, tenesmus, fever and dehydration.

Educare centre - A facility for day care of children. Children range from aged 9 months to 6 years. Activities are age dependent and both day care and educational in nature.

Enrolled nurses - Nurses enrolled with the SANC as such after a minimum of two years training. Called ‘staff nurse’ on the wards. Constitute 18.85% of nurses in SA.

HIV - Human immune deficiency virus

ICU - Intensive care unit

Idiopathic Thrombocytopenic Purpura (ITP) : A condition of unknown cause that is characterised by bleeding into the skin with the production of petechiae or ecchymoses and by haemorrhages into mucus membranes and that is associated with a reduction in circulating blood platelets and prolonged bleeding time.

Independent homelands - The areas established as independent states by apartheid policies in the 1960 and 1970’s. The stated intention of these was to return as many Black people as possible to these ‘homelands’ where political rights could be exercised (Chalmers, 1990: 101). Although these may have been geographically situated as ancestral land, the land was often undeveloped, under-resourced and typically rural. Unemployment in these areas exacerbated the problem of family disruption by migrant labour attracting especially men to the cities.
Informal settlement - A community of people living in makeshift housing on the peri-urban edge, usually highly mobile population of newly urbanised people.

Ja - 'Yes' in most of the languages used in South Africa.

Kwashiorkor: A severe protein-deficiency type of malnutrition of children. Occurs after the child is weaned. The clinical signs are, at first, a vague type of lethargy, apathy or irritability. Later there are failure to grow, mental deficiency increased susceptibility to infections, oedema, dermatitis, and liver enlargement.

Metastatic hepatoblastoma - Carcinoma of the liver which has metastasised to other parts of the body.

Pneumonia: Acute inflammation or infection of the lung.

Registered nurses - Professional nurses registered with the SANC after a minimum of three but usually four years of diploma or degree study. Mostly also hold a registration in midwifery, psychiatry and community nursing. In SA, as at end 1998, a total of 91 011 on the register, this means 1:416 RN : people in SA.

SANC - South African Nursing Council, the national accreditation (registering) body for nurses in South Africa.

Sister - The name by which registered nurses are called in clinical settings.

Staff nurse - The name by which enrolled nurses are called in clinical settings.

Trisomy 13: A genetic condition in which the child has three homologous chromosomes per cell instead of two in chromosome 13. Causes severe congenital deformation and mental retardation. These children usually do not survive past the first year of life. They have a large broad nose, widely spaced small eyes, low set ears and poorly formed lower jaw.

Sources:

Thomas CL (ed). Taber's Cyclopedic Medical Dictionary. Philadelphia. FA Davis Company 1989. (Cardiac Failure, Trisomy 13, Kwashiorkor)

References


Allen DG. The curriculum revolution: Radical Re-Visioning of Nursing Education. Journal of Nursing Education 1990; 29(7): 312-316.


Annells M. Grounded theory method, part I–Within the five moments of qualitative research. Nursing Inquiry 1997a; 4:120-129.


Bachelor JA, Briggs CM. Subject, project or self? Thoughts on ethical dilemmas for social and medical researchers. Social Science and Medicine 1994; 39(7) 949-954.


Child Health Policy Unit. Special report on the effects of free health care of children in clinics. Child Health Unit, University of Cape Town, 1999.


Coetzee M. Communicating Health in Pre-schools - the student nurses' role. Health Promoting Schools in South Africa: Challenges for the 21st Century. Conference proceedings; University of the Western Cape, Cape Town, 1996:244.

Coetzee M. Changes in the National Health system and what this requires of nurse practitioners. In: Third supplementary memorandum in support of a Bachelor of Nursing degree for Registered Nurses, University of Cape Town Nursing Department, 1998.


Curtin L. Going to the mat for what is right. Michigan nurse 1999; 72(10) :4.


Hanson LE, Smith, MJ. Nursing students perspectives: experiences of caring and not-so-caring interactions with faculty. Journal of Nursing Education 1996; 35(3): 105-112.


Lowenberg JS. Interpretive research methodology: broadening the dialogue. Advances in Nursing Science 1993; 16(2): 57-69.

Magen Z. Transpersonal commitments in adolescence: a cross-cultural perspective. Journal of Humanistic Psychology 1983; 23(4); 96-112.


Melia KM. "Tell it as it is" qualitative methodology and nursing research: understanding the student nurse's world. Journal of Advanced Nursing 1982; 7: 327-335.


Munhall PL. Nursing philosophy and nursing research: an apposition or opposition? Nursing Research 1982; 31(3): 176-177.


Palmer PJ. To know as we are known / a spirituality of education. San Francisco: Harper, 1983.


Reeves T. Educational paradigms. http://www.itech1.coe.uga.edu/Reeves.html -posted to the IT-forum list serve (21-02-96) - moderated by Dr Lloyd Beiber, University of Georgia, USA. Accessed by the researcher on 7 July 1997.


Shute A. Ethical decision making in medicine. Public lecture, Psychiatry Department, Valkenberg Hospital, Cape Town, May 1999.


Stewart D. The attitudes and attributes of student nurses: do they alter according to a person's diagnosis or sexuality and what is the effect of nursing training? Journal of Advanced Nursing 1999; 30(3); 740-748.


Watts, A. Some biblical principles and further thoughts concerning the place of relationships in education. Lecture notes, the Relationships Foundation. Cambridge, 1991.


Wilson, ME. Nursing student perspective of learning in a clinical setting. Journal of Nursing Education 1994; 33 (2): 81-86.


World Health Organisation. Nursing and the 38 European regional targets for health for all – a discussion paper. Copenhagen, Denmark; December 1986.


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Appendices
APPENDIX 1

PHILOSOPHY OF THE DEPARTMENT OF NURSING
University of Cape Town
1991

The Philosophy of the Department of Nursing at UCT emanates from our interpretation of the nurse's role in meeting the health needs of society and preparing graduate nurses for this task. We believe that:

Nursing is a creative, caring and goal directed service to individuals, families and communities, based on a sound body of knowledge. It aims to care for the whole person throughout life and in death; to promote, maintain and restore health; and to protect those who are vulnerable. Nursing aims to create and co-ordinate an environment which enhances the quality of life. Central to the practice of nursing is a commitment to relationship.

Education is a creative and dynamic process which occurs within the context of relationships and is aimed at the development of the whole person. Within the education process opportunities are provided for the learner to negotiate and attain desired goals through a variety of both structured and unstructured learning experiences. Inherent in this process is the recognition that adult learners take responsibility for their own learning, are self directed and are able to make informed choices.

Other concepts in this frame of reference are defined as:

Each person is unique and has value. He/she is an integral whole of body, mind and spirit. He/she is in search of meaning and fulfillment in his interaction with his environment. He/she has the potential to function optimally and creatively in the social, spiritual, physical, emotional and intellectual dimensions of his/her life and in these he/she exercises choice. Health is a state of physical, mental, social, emotional and spiritual soundness in man. It is a dynamic state which is relative rather than absolute and is achieved when there is integration and balance of man's internal and external environments.

Environment is the dynamic milieu which incorporates all internal and external factors that influence the quality of man's life and health.

Unpublished
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1991
APPENDIX 2

CONSENT FORM: M Sc (Nursing) data collection at the Children's Hospital

Title: Learning to nurse children - exploring what helps and hinders Bachelor of Nursing students.

Researcher: Minette Coetzee - Lecturer, Child Nursing Component.

Aim: To describe and analyse the process of learning to nurse children as experienced by a group of third year students.

Study benefits: In a climate of rapid change and increasing need amongst South African children, student nurses need to be as well prepared as is possible. The qualitative design of this study may prohibit generalisation, yet understanding the process of learning would certainly be useful in nursing education institutions where students are prepared to nurse children. Although not implicit in this investigation, more effective preparation of registered nurses will impact child health and child health care in this country.

Research procedures: Participant observation in the clinical setting, will be utilised to obtain data while the investigator is working with the undergraduate students at the Children's Hospital. These observations will be recorded onto audio-tape for transcription.

Students will be required to keep a clinical journal, describing their experiences in the clinical setting (hospital and community), as well as in the classroom.

Data will be recorded in a manner as to maintain confidentiality and anonymity. Any identifiable data will be recorded in such a way as to protect the identity of individuals (children, families, staff and students). It will however be difficult to prevent linking specific findings concerning the process of learning with a specific institution.

The researcher undertakes to disclose at her discretion, any relevant incidents to the Nursing Management of ......... The final report of the completed study will be made available to the institution.

The full proposal has been read and understood and consent to proceed with the study is given.

...........................................  ...........................................
CHIEF NURSING SERVICE MANAGER  MEDICAL SUPERINTENDENT

 .............  .............
DATE  DATE
With thanks,

Yours sincerely,

[Signature]

2nd March 1992
March 1995

Dear Minette,

I have read your research proposal (abstract) as well as your letter.

I agree to your doing participant observation of the group while I am present and part of the group, in the classroom or in the clinical setting - hospital or community.

I will also submit my clinical journal once a week by Wednesday morning and expect it back by Thursday. I will write about my experiences after clinical sessions as well as after any other learning encounters: class, own family visits & Shawxo. I am prepared to write short descriptions of insights or impressions when requested to.

I understand that such clinical journaling is a usual requirement of this component and if I decide not to consent to its use as data, I will still submit the journal.

I also understand that I need not tell anyone of my participation or non-participation in this study. I will communicate any problems or difficulties to you, and endeavour to keep lines of communication clear.

Incredibly, I understand that if I decide to withdraw, I may do so without any fear of recrimination.
Learning journals have been used in a variety of academic settings to promote student learning. In nursing curricula, a clinical learning journal is a record written by a student nurse that reflects attitudes, feelings and expansion of his or her cognitive learning throughout the nursing course.

Your initial experience of journaling in this setting, in your first year, may have helped you to recognize the value of this method.

You may have recognized the opportunity to focus on your unique experience in the wards and may have recognized the opportunity to express your feelings about experiences a little more clearly/easily and with emotion.

As you now embark on your third year of nursing - of Women's health and Children's nursing - you are encouraged to re-establish a Clinical Learning Journal.

Learning objectives:

In journaling you will be assisted to:

* Make the essential links between theory, research and clinical practice.
* Develop critical thinking by increasingly clarifying your thinking.
* Increasingly understand different roles in nursing.
* Increase your ability to empathize.
* Increase your ability to observe and describe.

Suggestions for Clinical Learning Journal:

The journal is a communication tool to document clinical learning, reflecting your personal style. It is a personal recording of the events of your clinical day, rather than an objective recording of academic data from classwork. Your journal will offer you an opportunity to share the application and integration of principles, theory and research in the clinical setting with your peers.
What to write:

1. An objective or goal for your clinical day (related to course competencies as listed in your clinical objectives).

2. Personal reactions to your clinical experience.

3. Notes about insights, new ideas, concepts and theories.

4. Your thoughts and feelings (such as your feelings as you witnessed your first childbirth).

5. Articulation of ethical dilemmas you may encounter.

6. Application of concepts and theory discussed in class as you move from theoretical to clinical practice. (You may want to reference such an entry; e.g., if you cared for an adolescent mother, note an article you read in a nursing journal about how adolescents differ in their ability to parent.)

7. Interactions/experiences with other health care providers (e.g. observations caring/non-caring behaviour, role-modelling, or client teaching).

How to write:

Make an entry for each clinical day and include all previous entries chronologically in a notebook or loose-leaf. Date each entry and write as soon as possible following your experience. Your journal should reflect active, regular use. Develop your thoughts as fully as possible rather than making a cursory listing of the events of the clinical day. Make the journal legible in pen or make journal entries on the computer. Include both "academic" and "personal" entries.

Evaluation:

Your journal entries will serve to remind you of experiences to share in the weekly Current Clinical Issues sessions. These entries serve to facilitate self-evaluation, but you are requested to submit your entries two weekly for guidance and comment. These will contribute 10% to your NUR306(f) yearmark.

REFERENCES:


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February 1994

Compiled by M. Coetzee
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APPENDIX 5

Conditional Matrix

International:
Human rights culture being entrenched with increased conventions → focus on women and child and third world issues → Nursing recognised as a discipline, theory developing → Education, participative & emancipatory from content-lead, product, authoritarian.

National:
New democracy → population of <16 year olds → disrupted families, due to family breakdown, urbanisation, migrant labour, matriarchal families, → crime and economy.

Community:
Urban and peri-urban. Varied student group, from local and distant communities, children nursed are mainly from lower socio economic backgrounds and in a tertiary health care setting.

Organisational & institutional:
Health care: tertiary care settings with aspects of secondary and primary care offered in the same setting. Task orientated approach, staff shortages in certain areas, move towards parents being welcome is only starting and is evidenced more in accommodation than involvement with care. Family-centred care is not the norm. University: a transforming institution with much change and yet also apparent stability and a respected power-base. Student involvement is encouraged and → community awareness and participation.

Sub-organisational & sub-institutional:
Wards – run with strict hierarchical structure, registered nurses are usually occupied with administrative and writing tasks → care mostly by supplementary professionals. Medical professional → lead and direct practice →

Group, individual & collective:
Student group, peer culture → senior students in the university setting, familiar with form and structure of governance, student affairs, department administration, time tables, classroom and teaching practices. In clinical settings that they do not know they are low on the hierarchical structure, they are unfamiliar with procedure and routine → often do not feel part of the team

Interaction:
Students have different levels of interactions with various people. Usually closest to peers and sometimes own family → familiar with teacher and other faculty → uncertain in relationships in clinical settings → “finding their feet”

Action ⇔ phenomenon: Students puzzling connection with children