Caring In Nursing Education

Bernadette M. Dragich

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James W. Garrison, Chairperson
Katherine R. Allen
John K. Burton
Betty R. Rader
Thomas M. Sherman

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(ABSTRACT)

Narratives are used to explore personal beliefs and assumptions about caring in one's personal and professional life. This dissertation recognizes the process of caring is interpretative and evolves from personal experience. I address issues of caring within the practice of nursing and nursing education from a feminist perspective. I begin with my own personal narrative in which I seek to uncover my own caring essence as a basis for inquiring into issues of caring and feminism in nursing education. Theoretical constructs from educational nursing and feminist literature are explored to develop a personal model of caring within nursing education. Nursing students must be educated within a caring learning environment so they can develop a caring stance with patients. Dialogue within teacher-student interaction is at the center of such an environment. This dialogue encourages authentic presence with students that leads to an intuitive knowing. Nursing students need to learn to let their intuitive sense guide the use of technology. Of course, that means educating their intuitions. Autobiographical vignettes are used to reflect on the experience of a nurse educator as caring guides teaching-learning activities in a nursing curriculum. Caring within clinical teaching encourages reflection and increases self-awareness. Clinical teaching is seen as an opportunity to unite theory and practice. It encourages students to be receptive to patients and places value on contextual experiences. An examination of contextual experience shows that care is relational and encourages connections with others. Care is sustained through relationships that give voice to nursing students and patients. This process of giving voice makes caring more visible to others. This visibility allows nurses to celebrate caring occasions and validates worth of caring in nursing. Caring practices within nursing education help students recognize the power within themselves to institute change. Nurse educators must encourage students to care for themselves. This process will help them stay in touch with what they need as individuals as they provide care to others.

Dedication

I am very proud of my sons Nick and Ben Mirabile. I can never tell them often enough how much I love and cherish them. I am very proud of their achievements, and I dedicate this dissertation to them.

Also, I lovingly want to honor my Great Aunt Margaret Takoch and my parents, Theresa and George Dragich. I regret they are unable to share the completion of this work with me.

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Preface

At one point, I have run from my past life and experiences that evoked negative thoughts. I have come to know by embracing my experiences as a woman, a nurse, and an educator I will know who I am. By knowing who I am, I could embrace what makes me different and then focus on my lived experiences and others. When we look at caring, it becomes a concept that is not abstractly categorical but intertwined in living. This intertwining involves giving voice to issues that give one understanding.

This understanding or particular meaning comes from my life story. Denzin (1989) says that a life story examines a life or a significant segment of a life. It becomes a narrative of personal experience (p. 42). From an epistemological standpoint, I need to examine my caring roots or essence. I need to examine those segments of my past that gave meaning to my assumptions about caring work. Walker (1995) says that narrative is a methodology that permits better understanding of the practice which shapes nursing. Nursing is an oral culture that has hidden contradictions. An examination of these contradictions shows that one must attend to multiple voices. As a feminist, I know I must attend to many voices, and I know I must interpret them consistently. Denzin (1989) says that biographical studies should examine how subjects attend to gender and presence. I learned caring from my Great Aunt Margaret and my mother. My father, though, gave me the first appreciation of contradiction in my life. I know he was oppressive to my mother and to others at times. Ironically, though, it was my father that encouraged education for his children. Education helped liberate me and helped me to redefine the feminist role for me.

Simple moments with my Great Aunt Margaret and my parents shaped how I chose to do the caring work of nursing, and I was later to redefine my life through the choices I made. Walker (1995) sees nursing as a culture that allows one to consider the inconsequential moments of personal experiences that shape an individual's understanding (pp. 156-157). I think this approach allows me to look at the cultural practices I am involved with, examine their impact, and reflect on how I came to perform them differently. I see this process as similar to reflexivity because the interpretative process is within the experience. Belenky et al. (1986) ask how do we know what we know. This knowing affects our definitions of ourselves, the way we interact with others, our public and private lives, our sense of control over life events, and our views of teaching and learning (p. 3). I am attempting to examine my experience and become more aware of the cultural scripts that have occurred within my life. Garrison (1997) sees narrative as

permitting one to make a discriminative judgment of what is valued. The use of narrative allows a structuring of one's experience that permits interpretation (pp. 144-146).

Caring is traditionally "women's work" and hence, considered invisible and devalued. By talking about my personal caring, I can make it more visible to others and myself. In order to do this, I need to be true to myself to avoid oppressive practices that hinder my caring work. This will enable me to move away from the oppressive roots and subordination history of nursing. This requires an awareness that avoids internalizing the values of the dominant culture, including sometimes, the culture of the academy. Caring is a practical and theoretical concept that has a degree of politics within the social realm. Caring nursing practice moves the practitioner away from a detached, objective, and scientistic world view.

A caring stance allows one to apply theory to care for that particular patient in that moment in time. It becomes a way of thinking in relationship to others. It is critical thinking because it involves observation and deciding what is important and requires looking for patterns. It involves identifying a need or concern that must be addressed for a particular individual. People have different values, beliefs, and culture. Caring involves understanding the context of the person's life and illness. Caring knowledge is gained through personal involvement with others. Health care can only make a difference if there is a movement away from treating people like robots. It is caring that guides one's technical competence.

Giving voice to my personal and practical experience validates the theoretical constructs I utilize in my professional life. Richardson (1990) says that narrative is a way in which humans organize their experience into time and meaning related episodes. It becomes a way to order experience and construct reality (p. 21). In my writing, I am constructing my lived experience as a nurse educator as well as how I give meaning to caring. Richardson (1990) further relates that narrative gives one the opportunity to make sense of mortality and make it sociologically accessible (p. 23). I see this making sense of mortality as processing and recapturing experiences in order to arrive at new understanding. In nursing, the simplest experiences sometimes have the most meaning. Nursing is not always as glamorous or exciting as portrayed by the media in television series like "ER." Significant moments in nursing are often mundane and drab. For example, it may seem unimportant to walk a patient to the bathroom. However, this simple act prevents the patient from having an accident in the bed and preserves the patient's dignity and self-esteem. The patient becomes an actual person with human needs rather than just someone who needs medical procedures. As a result, the nurse understands the patient and more

appropriately responds to the patient's care by completing this simple but necessary task. This new understanding is intricately tied to professional socialization. In order to help students do this, I need to locate my voice and stance within the culture of nursing to become a more effective teacher. I see it as moving beyond representation and toward seeing how our knowledge is constructed.

The construct of caring must be lived in order to embrace it. Caring is described in the literature as the essence of nursing and as a core concept in education. I want to know, what does caring mean to me as a nurse educator and why is it such a big part of my life. I see narrative as making thinking more visible and allowing one to see how knowledge is situated in experience.

I have recorded epiphanies that are significant events in my life. These turning points lead me to my core caring assumptions and validate a model of caring for me in nursing education. This story is about my lived experience in nursing education and not a summary of theories. Experience must be addressed with verisimilitude. I tried to represent my experience as real and truthful. I hope to convey an inner dialogue that allows me to connect with others. I see this as giving me a heightened sense of consciousness that I convey to my students and patients. I use the feminist interpretative method of reflexivity, to critique, reevaluate, and to validate my assumptions. This stance allows me to observe and reflect on situations that give me new understanding. It is an understanding that is culturally bound by time and place within the world of being a woman and a nurse. This understanding allows me to share my understanding of lived experience, rather than making generalizations about what I believe and do. This situated thinking values subjectivity and emotion. Hence, this stance leads me to write in first person narrative.

Greg's Story

I have seen Greg for several years in the community hospital where he worked as nursing assistant. We never really spoke until he entered the nursing program. I remembered him well because he was the big guy who was always gentle with his patients. He fluffed the pillow one more time for the patient he was transporting or placed an extra blanket on the person. Greg would start talking about fishing and hunting and get smiles across his patients' faces. He always seems to know the intimate details of the small communities that surround our town. My subjective stance was that he really was there for others. It was the way in which he related to

people. It was something I inherently knew from observing his interactions. He quietly took good care of his patients and his way of being left an indelible mark in the recesses of my mind.

He enrolled in school so he could become a registered nurse. He approached me one day in the hallway and said, "Ms. Dragich, you probably do not know me . . ." He was surprised when I told him I did know who he was, and I liked the way he interacted with his patients. This intuitiveness about Greg is not something I learned by reading theory. It is a heightened consciousness that allows me to see those qualities about him.

Witherall and Noddings (1991) say that the power of narrative and dialogue is in reflective awareness. A reflective awareness that leads to insights and compassionate judgment that create shared knowledge and meanings. These meanings deal with the aesthetic as well as everyday experience (pp. 8-9). Caring has been part of my life as a woman, nurse, and educator. Theory can validate my experience, but it is narrative that provides insight and compassion that opens new possibilities. I see this process as increased and heightened consciousness that allows me to more intensely experience caring as a nurse practitioner, teacher, and theoretician.

Witherall (1991) further relates that teaching is not a neutral activity and has identifiable assumptions regarding the nature of the self, and the self in relation to others and culture. I see this as meaning and experience in relationships that have guided me in developing a model of caring that is implemented through a caring curriculum. The caring curriculum is not contained within oneself but only in relation to others. My use of narrative writing allows me to examine socially embedded nursing knowledge and practice with feminist theoretical constructs. This examination decreases the distance from theory to actual practice. I hope it is a creative sharing of perspectives that shows the complex and contextual life of a nurse educator. I have attempted to examine caring from a holistic perspective in ways that make sense to me. My writing reminds me of who I am as well as the conflicts I have overcome to arrive at the point where I could begin writing this dissertation. Caring must be interpreted through experience and growth. It is through growth that an individual sense of agency is developed. Narrative allows me to listen to my voice as well as my students' and patients' voices. This promotes a sense of connection while I implement a model of caring through relationships with others. I use narrative vignettes to validate my understanding when I am in actual nursing situations. These contextual situations lead to my understanding which give me insight on how to interact and react.

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Chapter One: Autobiographical Vignettes

In recent years I find myself reflecting on my personal journey in becoming a nurse educator and a feminist. Cooper (1991) says that "it is the past selves that form the present collective self" (p. 27). Caring work and the subordination to others shaped my "past selves." My reflexive voice guides me in developing the following assumptions regarding caring. Caring is a way of being that connects us with others. Gordon (1996) says that caring is learning to be with others, seeing and hearing what is around us, with emphasis on the encounter and not the outcome. I think that emphasizing the encounter makes caring invisible and intangible. Caring work is appreciated within a dualistic framework. Women care for children while men produce an income. The professional woman works all week and has another woman clean her home. I struggle constantly with balancing caring work personally and professionally. I know that my beliefs stem from my personal experience over a lifetime.

My beliefs and actions are intricately tied to my socialization and world view. I was socialized to do caring work and value education in an oppressive environment. This socialization makes me sensitive to issues of personal and professional subordination.

For a long time, the roots of my beliefs and values about caring were silenced within me. These beliefs and values are the essence of my being a caring nurse educator. Gordon (1996) says that the home, the workplace, academics, and the community give expert knowledge and education regarding caring (p. 262). My caring essence originated within my great Aunt and mother who influenced my choice of nursing as a profession. An influence tempered by the fact they were marginalized because of family and social reasons. My family socialized me to do caring work and to follow a path of subordination. Therefore caring is intricately tied to issues of subordination and oppression for me.

My life story is simple and many may see it as their story. I see telling the story as giving new meaning to my lived experience. Reflecting on this meaning permits insight into my personal assumptions about caring work. Caring work is an important part of my life experience. Caring work has been visible and invisible and valued and not valued in my life. I ponder how these views of caring have impacted my life. This reflection of my lived experience gives meaning to my present self and is ever changing.

I was born in Uniontown, Pennsylvania, to George and Theresa Dragich on October 30, 1950. My parents lived near my grandparents' grocery store until 1958. I am the third of four

children. My two older brothers are George and Tom, and my sister Therese is younger. My mother and Aunt Margaret helped to formulate the foundation of my caring beliefs.

Mother

My mother was the eldest child of Mary and Ignac Susa who ran a small local grocery in a small western Pennsylvania town. Mary's father ran a large dairy farm on the outskirts of town. Ignac had recently immigrated to the United States from Croatia and was a butcher by trade. He worked as a coal miner when he first arrived in Pennsylvania. He met Mary when she made deliveries from her father's store to his boarding house. When Ignac saved enough money, he asked Mary's father for her hand in marriage. Mary's father sold the grocery store to Ignac when he and Mary became engaged. Their wedding reception was held in the basement of the grocery store.

Ignac had been in the United States only eight years when they married and took over the store. He felt very fortunate to be in the United States and a property owner. He was a good man who just did not know how to run a business. Mary, my grandmother, worked with her father on the farm and at the store. Therefore, grandmother managed the business end of running the store. My grandmother had to survive in a man's world when historically women were supposed to be in the home. My grandfather did not worry about paying bills and making a profit. He gave to those in need without question. It was grandmother who worried how the family would survive the depression and World War II. The family finances became my grandmother's concern, but she always made it appear that grandfather was in charge. Grandmother was adept at this already. Her mother had difficulty speaking English. Grandmother's father sent her and her mother back to the "old country" to live after her mother had several miscarriages. When they returned to the United States, my grandmother had to balance the "old world ways" with the productive work habits of her father. It was easy for her to assume these additional responsibilities when she married Ignac. She balanced the attentive mother role with the calculating shopkeeper. When it appeared her sister Margaret enjoyed caring for the children and the house, it was easy to allow Margaret to labor at home and not in the store. My mother, Theresa, became a very strong willed and gentle women. A testimony to the difference and similarity between Mary and Margaret. This was the beginning of the inherent paradox in my mother's life.

Mother wanted to complete high school, and it was my grandmother who told her this was not a woman's "lot." Her younger brother Louis would be the only one allowed to complete

school. The middle brother, William, was often ill and not fit to work full time or go to school. The tall, hazel eyed Theresa became a store clerk helping my grandmother with "figures" at age fifteen. She assisted my grandfather with cutting meat because Louis did not have any interest in the store. Everyone knew that William could not help very much.

Her parents needed her and she would say it was her duty to work in the family store. It was her duty because William was ill and everyone but my grandparents knew Louis would not stay in this quiet Pennsylvania border town. Her parents reminded her that women needed to prepare for marriage. My grandmother and Margaret could teach her cooking and stitchery skills in the afternoon. Mother just did not say much about those years. She would constantly talk about how she wanted to finish school but was not allowed to do so. She longed to be a teacher or a nurse, but it was not to be. Mother talked about long days in the store. She said that evenings were spent listening to the radio and playing cards. Margaret tried to teach her crocheting, and my grandmother wanted her to learn embroidery. Needle crafts did not interest her, and she sometimes wondered if she was not quite right. The feminine work she did was not interesting to her. She wondered about this when she would be washing the pillowcases and scarfs that Margaret and grandmother made. My grandmother would embroidery these pieces, and Margaret would crochet an edge. The words went something like this, "Grandma and Margaret tried to teach me, but I am hopeless." My Mother was not hopeless as much as frustrated because she could not follow her interests.

My grandparents loved to entertain in their huge backyard behind the store. The 1937 news clipping described the surprise nineteenth birthday party they held for my mother. There was a three tiered white cake frosted in blue icing. The evening was spent dancing and playing games. My grandfather played a bass tambourine before his marriage. I believed some of his Croatian friends played similar instruments at these functions. A lunch was served at a late hour and live music was furnished. There were over fifty guests, and my Aunt Margaret was the hostess. It was at family gatherings similar to this that someone arranged the first meeting between my parents.

Father

My father was the eldest child of a widow who lived in one of the outlying coal camps. He was working in one of the coke mines while looking for an electrician's job. When he met my mother, he seemed nice to her and was helping his mother financially. His father had been murdered years earlier in a bar room brawl. His mother could not speak enough English to

testify at the trial. Since the prosecution had only circumstantial evidence, no one was ever found guilty of his father's murder. His mother made him head of the household when he was fourteen. He was bringing home some money from spare jobs and served as an English facilitator for his mother. George was used to getting his way with the younger siblings, and this would continue with my mother.

My grandfather's "old country" friends knew the family and admired George for helping his mother. The friends thought he would be perfect for Theresa since they had the same birthday. After a year of dating, they decided to marry. My grandparents had an apartment that was attached to the store that would be perfect for the newlyweds. My strong willed grandmother and my father would clash over the wedding. My mother was caught in the middle of a feud that began on her wedding day and continued a lifetime.

My father thought shopkeepers could afford to rent a hall for their daughter's wedding. My grandmother wanted the reception in the backyard where they had family gatherings for years. My mother was happy with the backyard and desperately wanted peace. My parents wanted to be married on Friday, May 23 (their birthday), but my grandmother would not close the store on a Friday. My grandmother prevailed, and my parents were married on Wednesday, May 28, 1941. The wedding reception was held in the backyard. The wedding pictures show the family in formal dress except for my grandparents. My grandparents were dressed in their "shop attire." They kept the store open for part of the day while family and friends were at the church. Somehow whenever they managed to argue about anything, my father would bring up the wedding. My mother and Margaret would try to maintain peace between them. Mother was good at maintaining peace. I feel the more she did this, the more she began to lose her self. She lost her self because she kept burying her feelings, desires, and aspirations. My mother did not care for herself, she worried about how everyone else was feeling. Caring for other people was a way of being for my mother. This caring was intermixed in a spiral of subordination to others that started with grandmother and continued with my father.

My parents lived in Pennsylvania after they married, and my mother continued to work in the store. My father passed an electrician's exam and got a job with Westinghouse in West Virginia. They lived for several years in West Virginia where my father worked as an electrician. He had some type of accident where he lost his peripheral vision and could no longer work as an electrician. They moved back with my grandparents who were very happy to have them. My grandparents thought Louis was going to help them run the store. Uncle Louis

was getting married and his new wife wanted to live in Detroit. They needed my mother in the store to help grandfather with butchering and grandmother with the finances. My father repaired small appliances and radios in an area my grandparents fixed up on their property. It was as if everyone was happy for awhile. We were part of one big extended family that included my second cousins who were running great-grandfather's farm. We spent Sunday afternoons with my paternal grandmother who never came near the store. It was if she was out of her element with my maternal grandparents. She still had outdoor plumbing and spoke English only when she had to. Even as a child, it was easy to tell my father was the "apple of her eye." It was his sisters that took care of her daily needs and tried to make her life more comfortable. I sensed it was difficult for my father to go back to his past.

My grandparents needed my mother, and she seemed to thrive working with them. My Aunt Margaret would care for us when she was working or we would sneak in the store. My grandmother would send us away with a popsicle or penny candy. We would go play in the huge yard, or we would climb the mulberry tree down the street.

My father became impatient living in Uniontown. He was busy but not profitable; that's how it was with the store. He thought our family was too dependent on my maternal grandparents. He never gave my mother credit for what she was doing for the family. It was as if only he could provide for his family, and it was only his responsibility. My grandparents let us live rent free and gave us groceries as a form of compensation for mother's work, but my father saw it as charity from my strong willed grandmother. She was not quiet and passive like his mother. He resented that she ran things and made major decisions. My grandfather usually went along with her wishes, but it was his name on the store. My mother felt she needed to keep the peace between her parents. It seemed that she was always deferring to their wishes and compromising. I wished my mother could have told them what she wanted and needed. Mother talked about doing her duty as a wife and daughter; still her parents and husband were always fighting.

What kept the spark in her eyes was contact with her extended family and her relationship with her sister Margaret. She loved picking mushrooms and walnuts on the farm. Her cousins would take us to the dairy and tell us that the freckled cows gave chocolate milk. There would be a sparkle in her eyes when she would shake a finger my cousins for telling such a story. It was the very best chocolate milk, and we usually had homemade donuts with them.

Sometimes we went for a hay ride or just played in the barn. We would go home with whole milk with cream on the top, fresh butter, and "smear case"--a homemade cottage cheese.

There was still an uneasiness in her mother when my father was called back to work at Westinghouse. She did not want to leave, and they did not have the money to buy a house. We stayed in Pennsylvania and my father visited on the weekends. Weekends were spent at my paternal grandmother's church. Sometimes my father would take us to a drive-in movie. About this time, we were the first family in the area to have a television that he built. This was a source of pride for my mother and grandmother. Again it seemed like we were a happy extended family. My family would pose for a picture and then there would be a picture with my grandparents and uncle. For some reason, my grandmother would not always allow Margaret to be in these pictures. I remember crying for Margaret to be in the pictures and being told that it was just for grandma and grandpa. At a later time, Margaret is in all our important pictures but my mother is missing because she is the one taking the pictures. It was one of those things my mother quietly did for Margaret so she could feel as if she belonged.

Great Aunt Margaret

Aunt Margaret grew up on a diary farm in Pennsylvania. Her family consisted of three boys and four girls. My grandmother was the oldest child and there was a brother who was younger than Margaret. My great-grandfather sent Margaret to live with my grandmother when she was twelve. When Margaret was upset she repeated her father's words, "Margaret, you are useless! I am so sorry that you were even born!" She said that he always favored the younger brother over her. Why did he not send any of his other daughters away? Margaret left school at twelve to help in my grandparents' store and to care for my mother and her brothers.

Grandmother had three young children and was given Margaret to raise. She loved Margaret but resented the circumstances surrounding Margaret's entry into her family. "I gave you a home when our father did not want you. All you want to do is stay home and take care of the house." When money was tight, it was Margaret's fault because she was an extra person at the dinner table. Grandmother said that Margaret had to work in the store for "room and board" and take care of the house. Margaret never received a salary from my grandparents. Later it was difficult for her to get Medicare coverage because she never paid into social security. My grandparents bought her clothes and gave her spending money. Growing up, it just seemed that Margaret was always "behind the scene." She did some of the cooking, washing, housecleaning, tended the chickens, and helped in the store. It just seemed it was never enough for

grandmother. When the resentment surfaced, they discussed their father. It seemed no one ever questioned him or his motives. They termed their mother a silent but good woman. I always wondered how she could let Margaret go. I think Margaret thought about that often and just would refuse to say much about her mother. Margaret needed to love someone unconditionally, and I was one of the lucky beneficiaries of this need.

Words are not adequate to describe Margaret. She dressed very simple and wore a hairnet. She wore these black shoes that looked like the shoes that nuns would wear. Her touch was soft and soothing but her hands were rough. The rough hands came from hard work. It was the kind of work nobody else would do, such as tending the chickens and washing and ironing clothes. She washed clothes with an ancient wringer washer and once incurred an injury that left an odd shaped finger. She joked about this finger and would shake it when we did something to her disliking. She was simple, soft, and rough at the edges. She was not fancy but smothered you with love. You knew you were important to her and what you did really mattered. She was not about fancy gifts but showing up and being there for you. Youth tends to value the material aspects and not the personal connection. She was there for the important steps, decisions, and turning points in my life--both happy and sad. Margaret's gift was in connecting with another and making that person the center of attention. She had this passionate sense of valuing the moment and taking pleasure in the quiet elements of life. These moments were quiet reflections about stillness of the night air while sitting on my grandmother's back porch. As a young child, I remembered how she could softly touch my face when I was upset and my woes would disappear.

We would get eggs from the hens' house with Margaret and later dye them for Easter. Early Easter morning, she sneaked out of the house and would hide those eggs. She would laugh and say it was the Easter Bunny, but they sure looked like the eggs that we dyed the night before. This activity was better than an Easter basket because it was a joyful imprint in my life. It was joyous because we were connected with others and showered with her loving attention. Store bought Easter baskets could never equal this joyful gift. A joy that valued living and being connected with others. She made you the center of her attention and was always there on the periphery. I often wonder if that is why her father sent her away. She was more about nurturing others than producing a marketable commodity. The greatest gift she gave was her love. We only had to open up our hearts and souls to receive it.

When Margaret died there was an old tattered suitcase tied with a piece of cloth. My mother had tried to dispose of this suitcase twenty years ago. This suitcase was filled with newspaper clippings and pictures about my family. My oldest brother said that the "old girl" had nothing of value and made an innocent snicker. I have been haunted by this remark because her possessions were not worldly but had impacted all of our lives. It was Margaret who had stopped his bleeding and bandaged his cuts and scrapes with pieces of freshly laundered cloth. Death is not a time of collecting inheritances but of claiming your legacy. Margaret's legacy was that she saw the potential in each of us. She nurtured that potential before you were even aware you possessed it. This suitcase had clippings and pictures that celebrated each small step her family took toward reaching that potential.

How did Margaret help me reach my potential? I think about this often, and I am not sure if I have an exact answer. She was always there in my life. Sometimes she was there more so than other times. My fondest memories of her were when I was in nursing school in Pennsylvania. It looked like I would never be able to go to nursing school in West Virginia. My father decided I should go to school where my grandmother lived. I felt I was just dropped off and forgotten. My father told me that I would have to stay weekends with my grandmother. My grandmother was a very fussy and an often ill woman. Margaret was caring for her and a nephew, William, who had Parkinson's Disease. Margaret knew how impossible my father could be. She made a point of making the weekends very special. We would catch a bus to go downtown where she cleaned a lawyer's office for extra money, and she would insist I study in the waiting area. When she was done, we would browse through the Murphy's Five and Dime store. She would buy me some small frivolous gift like scented soap. Next, we would have a "treat" at Hagan's ice cream store or get some marvelous cookies from the bakery across the street. Finally, we walked home and I told her about my week at school while she listened attentively. I would always have a stack of freshly laundered clothes to take to school. She seemed to enjoy and take pride in starching my nurse's hat. It was a chore to others, but she knew the right mix or combination of Argo's liquid starch. When my grandmother was not around, she would give me extra money, but I was not to tell anyone that she was doing this.

I remember when my appendix ruptured, my mother stayed in West Virginia while my father briefly visited me. It was decided Margaret could care for me until it was time to go home for Thanksgiving. Margaret was in her late sixties by this time and couldn't drive. She arranged for a neighbor to bring me to grandmother's house. I slept in her bedroom while she slept on the

couch. I thought I was isolated from my family who lived in another state. Margaret eased that sense of isolation with support, care, and kindness.

Her support is evident in the times I wanted to be away from school. I would walk to my grandmother's house. We would have dinner and then retire to the living room. Margaret and I would crochet afghans while grandmother and Uncle William would watch television. When I was ready to leave, Margaret would walk with me half way to the hospital. Half way was near a little family store where she would stand under a street light and watch me go up the hill. I would turn and wave goodbye to her. I can still see her in my mind when I look at those old afghans we crocheted long ago.

When I reflect on my past life, I still see her there under that street light. I am so sorry I ignored her when I was married. After I graduated and left Pennsylvania, going back was difficult. I just did not give Margaret the attention she deserved. I knew she had been treated poorly by her father. She liked to care and nurture individuals, but her father wanted her to work the farm. I wanted to walk away from my past and begin a new life. This new life centered on more education and my future husband. In the years after we moved to West Virginia, I missed having Aunt Margaret around and longed to go back to Pennsylvania to visit her.

The Fairmont Years

My oldest brother, George, lived in West Virginia for two years with my father while attending a Catholic high school. My next oldest brother, Tom, was double promoted and ready for high school. My father said that we had to move to West Virginia to be with them. The problem was that he did not have spare time because he was involved in the union. I was in second grade and very unhappy. My mother was devastated because my father said that now she could learn to keep house. The reality was the grocery store was doing less business. With more large chain markets coming to town, my grandparents thought they would have to retire. My grandmother did not like the house but said that my mother's place was with her husband. I was unhappy at school and hated the house. My brothers would walk me to school across what was called the low level bridge. I was scared because I could see the water beneath the boards as we walked. The hardest thing was the spark was leaving my mother's eyes and Margaret was not around to hug me. It was very difficult for me to get through second grade. My mother was called in for conferences because I was unhappy. My mother had to walk across that bridge with my sister in hand. I survived that year but was always a little different. Soon I was guiding my

sister across that bridge after my mother made sure we crossed the busy intersection safely. My mother lost part of herself that year, and it would be years before she would sparkle again.

Mother was caught in what it meant to be female, a wife, and a daughter. It was compounded because my grandmother often assumed a male "script." My mother saw my grandmother acting different from what she thought a woman should. My mother began to challenge issues but never followed through. She never sought any resolution about the house in Fairmont, West Virginia, she would just "grin and bear it." She took care of us in that awful house that my father never really got around to remodeling. He would fix something but then leave something else undone for years. I feel she did not speak up until later because she believed she should be submissive to her husband. Mother became good at seeing and hearing what people were doing when she encountered them. She became involved in church and neighborhood activities because they gave her a sense of community. She was always working dinners to raise money for various causes. She was not always in there cooking but often doing the jobs no one else would do. Anywhere we went, people would come up and speak to her. When I was sixteen, she baked bread for two days to raise money so I could go to Williamsburg with the Girl Scouts.

She was always doing something behind the scenes that I didn't appreciate in my youth. After her father died, she was always trying to be sure that grandmother, William, and Margaret were all right. This is when my grandmother realized what money was left from the store was best left in my mother's control. She would care for William into an advanced state of Parkinson's disease. Years later my grandmother became gravely ill. Grandmother told Uncle Louis that she knew my mother would care for William and Margaret and she was the best person to take care of the finances. I remember Louis storming out and saying that it was his role to control the money as the healthy male in the family. Louis made one or two visits a year to see grandmother. He never realized how ill my grandmother was until she died. At grandmother's funeral, he saw for the first time how immobile and fragile his brother, William, was.

I always felt different growing up, mostly over the following trivial facts. George is named after my father and Tom is named after my maternal grandfather. Therese is named in honor of my mother. I am named Bernadette because of Our Lady of Lourdes. My mother received a music box from the Saint Bernadette of Lourdes shrine just days before I was born. A favorite priest sent her the music box. The other fact relates to birthdays. My parents were both

born on May 23. George was born on December 6, Tom was born on February 6, and Therese was born on March 6, and but Bernadette was different coming on the 30th of October. My parents liked to repeat these facts and would say that I was different. My mother kept the music box on a bookcase and would show it to visitors. She would tell the story of how I was named. One day my brothers were fighting and knocked the music box off the bookcase. My mother was very angry at them. I remember I had never seen her that angry. It was then I realized that my name had some significance to her. When my birthday came around, they would comment how I was different since I was not born on the sixth or the twenty-third of the month. While this was all pretty harmless, I began to view myself as different. I thought I was different than the rest of the family, although I did feel they loved me.

I think I was a happy child living in Pennsylvania near my grandparents. I dearly loved my Great Aunt Margaret. She was the most marvelous woman in the world to me. I loved my mother but Margaret was special. I was so unhappy when we moved to Fairmont, West Virginia, in 1958. This was the first time I was away from Margaret. She hugged me the day we moved and said that she would care for me for the rest of her life. I told her how much I loved her and asked my father if he we could take her to West Virginia. I think she would have gone but my grandmother said that she needed her in the store. My mother said with tears in eyes that Margaret needed to care for Uncle William. My father grabbed me and put me in the car. I was holding on to Margaret's apron and she was holding on to me. She said, "Go Bernie, you need to be with your mom and dad." "I want to be with you, Margaret." She and my grandparents waved from the front of their store as our car left and went up Emerald Street. For years I can still see Margaret with my grandparents as we went up Emerald Street in all my dreams and reflection.

My family settled into that ugly, large house on the corner of East Park Avenue and Brighton Street in Fairmont, West Virginia. My father called it a "fixer-upper." He always was working on something. He claimed he never had time to finish it or enough money. I always thought the house was unattractive. There was a Red Head gas station across the street with railroad tracks behind the station. What I did like was you could go on the front porch and read the current time from the clock on top of the First National Bank of Fairmont. As a child I was impressed that Fairmont's American Legion had a Statue of Liberty in their front yard. I was in awe of it whenever we crossed the high level bridge. Growing up, we had only one car and my mother did not drive. If we wanted to go anywhere, we walked. If you walked anywhere in

Fairmont, you had to cross either the high level or low level bridge. We walked regularly across the low level bridge to go to Saint Peter's School. My mother always made sure we crossed East Park Street safely before we walked to school. She crossed the street with us and hugged us goodbye. We held hands as we walked. My brother Tom would hold my hand tighter when we crossed the low level bridge. I was scared of it as a little girl. You could see the Monongalia River below. I was afraid of falling through the slants. When my sister and I started to walk together, I held her hand tight like Tom had held mine.

My mother bundled us up when it was cold or snowy. There was a chilling wind off that bridge in the winter. We left the bridge and walked up a huge hill that led into town. A sense of relief came over me when I saw the Golden Brothers Department Store. I knew school was nearby. We would cross the street at Golden Brothers because there was a traffic light there. The side street that headed to Saint Peter's School had the grim looking Madison Hotel on the right and a funeral home on the left. I remember smelling alcohol on men who sat in front of the Madison Hotel. Sometimes I wondered if my parents would use that funeral home if I accidently fell in the river. Every now and then my brother walked me through G. C. Murphy's. We admired the candy counter, but we never had money to buy. If we wanted candy, we had to wait until we visited our grandparents and then could also go the toy department and leave through the back door near the toys. Next my brother and I would walk home across the high level bridge and pass near the Statue of Liberty on the American Legion lawn. At the left corner of the bridge, Yann's Hot Dogs sat. A spicy smell and the scent of hot dogs came from the screen door of Yann's. The smells or thoughts of candy and hot dogs would make us hungry when we got home. My mother always had a snack ready for us when we came up Brighton Street.

It became a chore to walk to school when I was older, because other kids were being driven. I resented it when they would pass us by and wave. Sometimes Mrs. Connell stopped in her Rambler to give us a ride. I questioned my mother about why she did not drive us. She said that my dad needed the car, and he did not come home until nine and school started at eight in the morning. When I walked through G. C. Murphy's, I longed for the things we could not afford. I no longer was happy to savor the smells and look at the toys. I complained to my mother frequently. She usually was patient and said that I was too frivolous.

Later I realized she sacrificed a lot so her children could have material possessions. When I was longing for material possessions, my parents were putting my brothers through college. I am not aware if any financial aid was available at that time. My dad paid all the

college bills and insisted all four of us go to West Virginia University. Fairmont State was across town and would have been cheaper than the university, but he refused to discuss it when Tom mentioned it. My mother supported Dad on this decision. They said in unison that they did not get the chance to finish high school or college. Their children would not be denied the opportunity to attend the university. As if they were joining in a chorus, they said that it was especially important for the girls to finish college. My dad scoffed when I took home economics. "You can learn that later, Bernie." He directed me to science and mathematics. He was extremely proud when I won a prize at the regional science fair. He even took off work to drive me to Huntington, West Virginia, for the competition. He never took off work unless he thought it was important. I marveled at the possibilities, but I came back from the science fair thinking my choices were limited. I thought I could only become a social worker, nurse, or teacher. I never considered going to medical school or law school. I was smart enough and my parents were supportive, I just thought I could never do it. My thoughts centered on a college degree and getting married. My parents reminded me I would be the first female high school graduate in the family. The thoughts of being the first woman in college were scary to me--I did not know what to do. I missed having my brothers around, especially Tom, who always knew what to do and gave good advice.

I finished my junior year in high school before Tom left for Alabama. He was the personnel officer at the helicopter school at Fort Rucker. My parents were extremely proud both sons were college graduates and commissioned officers in the Army. They worried about George being in the ordinance corp in Korea. Later there was the chance that Tom would be sent to Vietnam. My mother would say, "My Tom is so gentle and caring."

When my parents fought, my mother always lost. Their fights were verbal arguments about trivial stuff, but dad was very dominating. He believed a wife was subordinate to the husband. He would leave the house with my mother at the door sobbing, and she stood looking outside long after he was gone. I can remember Tom coming to the door and talking to her. She would be calm and could function again. It seemed as if their verbal warfare increased when my brothers were gone. My mother would cry for hours after the fights and could not do anything. My sister and I did not know how or what to do to console her. She missed both my brothers but seemed to need Tom more. Tom had a special way with her as with everyone. It seemed like her self-esteem was not quite so damaged when Tom was around to console her. While Tom as on leave, he made me feel better after I was not asked to the prom by a particular guy. However,

soon it was time for him to go back to Alabama. My sister, mother, and I cried for hours because he was gone. My dad missed him too but said, "We were a bunch of sissies."

Dad did have one tender moment. Tom wrote and called regularly. He always told mom not to pay so much attention to Dad. While George wrote or called us when he could, there was a stretch of time when we did not hear from him. Even Tom had not heard from George. My parents worried and prayed that he was alright. My dad then made phone calls to some government officials, the Army, and our congressman. Two days after he called our congressman's office, George called from Korea. My parents were relieved, and my dad got down on his knees and thanked the Lord. I am not sure why we did not hear from George. Tom loves to tell this story to his nephews and nieces. He ends the story by saying at least your parents have not called a congressman's office looking for you.

Shortly after the congressman incident, my dad became unhappy with Sister Rita, the principal at the Catholic high school. He announced at the supper table that his children would attend public school in the fall. My mother said that my dad was the head of the family and if he decided Therese and I needed to go to public school, then so be it. I transferred to East Fairmont High School when I was a senior. My brothers wanted to know what was up with my dad. It was out of character for him to allow his daughters to go to public school. I was kind of glad to be out of Saint Peter's because I did not feel as if I fit in with the others. If I did not fit in, at least I could get lost in the crowd at East Fairmont. I walked up the alley behind our house and finished my senior year at East Fairmont. My graduation in June 1968 was a huge family celebration. Our relatives from Pennsylvania came, mother cooked a huge meal for the family, and I remember people sitting and talking around the kitchen table. My grandmother marveled that girls were finishing high school now and wondered why I was going to college. "Oh, George are you sure that you want to spend money educating a girl?" "Now Mary the times are different, and girls need to be educated too. My Bernadette is going to be a registered nurse." I did want to do something in the medical field since I had been a "candy stripper" at Fairmont General Hospital. It just seemed being a nurse was the right thing for me.

I enrolled at West Virginia University in the Fall of 1968. My brothers did not stay in a dormitory, but the university would not allow freshmen women to live off campus. Therefore, I lived in the dormitory and had to interact with the other women there. I had problems the minute I walked in Arnold Hall. My roommate was an upperclassman and had more worldly ways. It was near the end of the semester before I figured out how to study there. I applied to the School

of Nursing like all other freshmen pre-nursing students. The letter came near the end of the spring break stating I would not be admitted to their sophomore class. My 2.7 average last semester was not good enough for admission. My grades were good second semester, but that did not count. I was devastated and thought I let my parents down. I told my parents I was not going to waste another year at the university. I decided I would just go into social work and did not have to be a nurse, but my dad would not hear it and lectured me on not giving up on my dreams. He suggested we investigate the diploma school of nursing at Uniontown Hospital in Pennsylvania. He understood Uniontown had an agreement with Pennsylvania State University. I could continue after graduation from Uniontown and obtain a college degree. I could stay at my grandmother's house on weekends, so if I needed anything, there would be relatives to contact.

One week after the rejection letter came, he took a day off from work to drive me to Pittsburgh to take the pre-admissions test. I was so impressed with the size and architecture of the buildings near the Medical Center at the University of Pittsburgh. I was filled with awe of the high surroundings and feared I would fail again. After I took the test, we drove on state route 51 to Uniontown to have dinner at my grandmother's house. There was a car wreck, and we stopped to help the people. I really did not do anything but hold the lady's hand while my dad flagged for help. He told everyone he knew I would be a good nurse by the way I handled myself that day. It was well after supper when we arrived at grandmother's house.

Grandmother and Aunt Margaret had chicken soup with Farina dumplings waiting for us that evening. Aunt Margaret said that she was thrilled I was coming to Uniontown. I reminded her I needed to be accepted into the program. My dad said that he did not think that would be a problem. I was cautious because of West Virginia University's rejection. I thought maybe Uniontown would not be so bad and was pleased it would not be a financial burden on my family. My dad was right and I was accepted at Uniontown. I finished out the spring semester at West Virginia and then left for Uniontown.

I started nursing school in June 1969 in Uniontown. The school of nursing was across the street from the hospital. We took our meals in the hospital cafeteria and did our clinical experience there. Classes were taught on the first floor of nursing building, and the students lived on the second and third floors. I thought this dormitory was more comfortable than Arnold Hall at the university. It had a huge living room with wing-backed chairs and comfortable couches. Psychologically, it was a more protective environment. If there was a problem, there

was a housemother available to help. The housemothers were matronly women rather than resident assistants. All student nurses had to leave the dormitory on Friday afternoon and could not return until Sunday afternoon. Each Friday, Aunt Margaret and Frank came to pick me up in my late grandfather's 1950 Packard. Since Aunt Margaret or my grandmother did not have a driver's license, their neighbor Frank, who had a license but no car, drove my late grandfather's Packard. Aunt Margaret would be waving furiously from the window of the blue Packard. Frank always wore a black vest and hat. They made an eccentric pair in the Packard, even in those days. I dearly loved Aunt Margaret, but I was often embarrassed. She always insisted on coming in the building to talk with the housemother on duty. They soon called her Aunt Margaret, too. My dad said that he was too busy to pick me up and take me to Fairmont. I spent a lot of time in Uniontown at grandmother's house. If Frank did not take us in the Packard, then Aunt Margaret and I walked where we needed to go. Aunt Margaret and I walked the three and one-half miles to the Uniontown Shopping Center. We went to Kresege's and the A & P and walked home pushing a portable cart along the side of the highway. Frank drove us to Saint Mary's church on Sunday morning. Sunday dinner was a pot roast or a baked chicken. Around three o'clock in the afternoon, they took me back to school. Aunt Margaret had my clothes neatly washed, ironed, and placed on hangers. The hangers were always tied with a white cloth. We carried my other belongings in shopping bags because I did not have a suitcase. Aunt Margaret loved collecting new shopping bags for me.

I was half through my first year of nursing school when Tom returned to West Virginia, where he accepted a teaching position at Fairmont Senior High School. It was Tom who brought me home to Fairmont and brought my mother and sister back to Uniontown to visit us. My mother seemed happier when he returned although my parents still argued frequently. He wanted my mother to be happier. It seemed like I saw my family more when Tom returned. I felt less isolated from them when I was in Uniontown, and Aunt Margaret made it more tolerable. I still was very bitter toward West Virginia University. I balked when Tom suggested I return there when I completed my diploma requirements. He kept working on me as I approached graduation. We would be driving back into West Virginia, and he would start to sing "Take Me Home Country Roads." Nonetheless, I insisted I was going to Pennsylvania State when I finished. Eventually it did not matter; my dad had a heart attack and needed coronary artery bypass surgery. My family wanted me at home to help, and Tom said that we needed to pull together.

The Morgantown Years

I agreed to return to Morgantown and allow my sister to live with me. Tom said that it was the only way my parents could afford to send her to college. I soon realized Tom and George were helping pay bills while my father was ill. I did not want to go back, but I thought it was the right thing to do. I applied to the school of nursing as a registered nurse student. I was accepted into West Virginia University's School of Nursing, contingent on my successfully completing the diploma program. I obtained a position as a registered nurse at University Hospital in Morgantown, West Virginia.

In the Summer of 1972, my family celebrated my sister's high school graduation, my father's successful surgery, and my nursing school graduation. My dad's sisters and brothers came as well as my grandmother's family. I felt like a beauty queen in my white uniform and the red roses they gave us before the graduation ceremony. My immediate and extended family was very proud of me. I was the first female to graduate from a professional program. They kept offering congratulations, but I kept having strange thoughts. I felt like I settled for less since I was not a college graduate. I thought I let my father down since I was not successful at West Virginia University. However, I was the only one with these thoughts because my parents were very proud. At dinner my uncle and brother George commented I should begin working on my "MRS"degree. They laughed and said maybe I would marry a doctor. We did not realize how prophetic our words would prove.

I met Charles when I was walking to the hospital one day. He thought it was interesting I was a registered nurse who returned to school. We discovered we both lived in the same apartment complex below the Medical Center. He was a third year medical student and had just started his clinical rotations. I kept thinking I did not need to be dating anyone at this time. He kept coming by the apartment I shared with my sister or my nursing unit. He offered to help me with class work. I was in love by the time we were both ready to graduate from West Virginia University. Charles went to North Carolina Baptist Hospital for his residency, and I went to Parkersburg Community College to teach nursing. Charles said that he wanted to complete his internship before getting married.

There was nothing special about Parkersburg except it was not Morgantown. Morgantown had too many memories of Charles who did not want to get married at this time. I was tired of the university too since he would be gone. It seemed as if the faculty was not accepting of the registered nurse students. It was if they were always putting up unnecessary

roadblocks. I could not see how my registered nurse role would be different with the bachelor of science degree in Morgantown. I saw Parkersburg Community College's advertisement and decided to apply. I knew nothing about teaching, but I wanted a challenge. I especially needed a challenge if Charles was not going to be around. I got the job and promised my parents I would visit them frequently. I assured them it would not be a problem since Fairmont was only two hours away. Their concern was I would always be in North Carolina visiting Charles. They were right because I did spend a lot of time with him in North Carolina and ignored them. I do not think I was a very good teacher either. My mind was on Charles and I wanted to get married. I could not think of anything else and did not work on developing my teaching skills. I only went through the motion of teaching. I just put in time at Parkersburg and thought of leaving frequently. I stayed because we were getting married in April when Charles would take me away from West Virginia forever.

Marriage

I married Charles on April 24, 1976, in Fairmont, West Virginia. Our wedding was at the Immaculate Conception Church. The wedding reception was at the Holiday Inn in Fairmont. I did not think he could afford the Holiday Inn, and it was not my first choice. Both Tom and my father said since I was marrying a doctor, the reception needed to be at a nice place. My dad kissed me at the reception and said, "Bernie, you did well marrying a doctor, I am proud of you." My mother kept repeating that her son-in-law was a doctor. After the reception, we drove to Pittsburgh in Charley's 1975 silver Chevy Impala for a brief honeymoon. After the weekend, we returned to Parkersburg to complete the last week of my contract. We packed up my belongings and returned my apartment keys on a Friday afternoon. I followed Charley's Impala in my yellow Plymouth as we left Parkersburg on Interstate 77 South. I was so happy to be leaving West Virginia, and I was married to a doctor. I did not anticipate a problem in the world. The world was at my finger tips. Charley would take care of everything, and we would be happy. I was heading south to a better life. His world became my world, and I left my family with all its troubles and woes.

I was unable to get a job teaching nursing full-time. I worked as a registered nurse at North Caroling Baptist Hospital in Winston-Salem. While I had been a nurse for four years, I immediately felt overwhelmed at this facility. It was so huge and understaffed, and I was constantly challenged by their technology. I had never seen technology like that in West Virginia. Their medical students and residents were different than West Virginia University's

staff. West Virginia's medical staff had a more collegial relationship with the nursing staff. At North Carolina Baptist, the medical staff seemed to view nurses as entirely subservient to them. The nursing staff needed to be technically proficient in a very changing environment. I was overwhelmed at work because of all the technology. Since I would not allow myself to be subservient to a physician or medical student, I was counseled by my nurse manager because I did not attend to the physician's needs. Additionally, my marriage to Charley and life with him was not the "bed of roses" I thought it would be.

Charley was as controlling as my father, and I rarely challenged what he said or did. I had seen my parents argue and it was not productive. While I challenged subservience in my professional life, I embraced it in my personal life. I did everything to make Charley happy. I embraced his Aunt's bit of wisdom when she said, "It was a woman's place to grin and bear it." If he was happy, then the marriage would work. I did not take care of myself. For a while I thought I was happy, then we got the call from a friend who was treating my mother. My mother had colon cancer and the prognosis was poor. I was upset about my mother and pregnant with our first son. I was upstairs crying in our bedroom when Charles came in and banged the door. He was very angry and said, "Why is this happening now! I expect you will want to go and see her!" He was yelling at me when I expected comfort. I am not sure what happened next, but we went and saw my mother. My family turned to him for advice about my mother which he reluctantly gave. My family was so impressed with his demeanor--it was the way that he was with everyone. He was not at all like that with me. Further, he was unhappy with my pregnancy. It was all my fault I was pregnant. I never intended to get pregnant, but it happened, and I was glad my mother would see my child.

Nicholas was born on February 17, 1978, on a cold winter weekend in Winston-Salem, North Carolina. No one came to see our new son. His family was closer, yet refused to come when he asked them. They wanted to wait until spring to see him. They knew my family could not come. I was sure his family would come because my family was unable. My family was caring for my mother who had major surgery for her cancer. I thought there would be someone to care for me--it seemed as if this was the way with other families. I had one consolation though, Charley sent me flowers and said, "I made him so proud." I thought, "Maybe he was coming around and would want our child too." He did not want to help much, and said, "I am the major breadwinner, and you will have to do everything until you go back to work." I felt so alone with a new baby. My mother worried about me. She wanted to put Aunt Margaret on a

bus and send her to North Carolina. I did not think it was a good idea because Aunt Margaret was close to seventy years of age. She once missed a connection from Pennsylvania to West Virginia and got so upset. I did not want to put her through a long bus trip. I learned to survive with a new baby and soon returned to work. I wondered if I had not married a man like my father. I kept telling myself it would get better when he finished his internal medicine residency, but it did not get better--it only seemed to get worse.

When Charley finished his residency he took a position with a Health Maintenance Organization. We bought a new home in the suburbs, and I was pregnant with our second child. I thought things were finally falling into place for us. Then my mother got worse and his grandfather became ill. There was a succession of relatives that visited us while his grandfather and my mother got treatment at North Carolina Baptist Hospital. I think we mutually resented each other's family being in our home. My family seemed to follow my behavior and did not want to upset Charley. His family was unhappy with me and did not like me working outside our home. It seemed as if I could not cook or clean to please them. I did not like what they said about me, so I tried harder. However, I could not please them. I could not make pudding from scratch or seven minute icing, but I kept trying. Mother was terminal in West Virginia and could not make it back to North Carolina. I knew she was dying and called her frequently. Aunt Margaret would answer and cry, "She is so uncomfortable, Bernie." My mother would get on the phone and moan, "I hope God will take me soon." I did not know what to do except to call. Charley complained that the phone bill was ninety dollars. The next month it was ninety dollars and some cents, so I hid the bill from him and went to the phone company. I wrote a check for sixty dollars and paid the rest in cash so he would not know. I was determined to talk to my mother. I thought she was dying but no one in my family would say that she was dying. I felt they were thinking it but could not put their thoughts into words. I needed to connect with her on some deep level.

When the call came from my family that my mother died, our second child was due in two weeks. I was totally numb inside. My mother was gone! Charley suggested I should not go to the funeral since our child was due and I agreed not to go. I went along with his decision since he was my husband. I made a mistake and I have always regretted it. I should have gone to my mother's funeral. We stayed in Winston-Salem and his parents went to the funeral on our behalf. Charley got the day off since his mother-in-law died. We said nothing the day my family buried my mother. For years, I have had trouble coping with this fact. How could I be so

uncaring? Why did I not follow my heart and return to say goodbye to her? Charley was home all day with me. I cried for my mother in our bedroom. I thought he would come to comfort me. When I realized it was time to feed my son, I started preparing Nick's food and Charley said, "We should go out and buy tires for my car." I knew at that time I should have gone to my mother's funeral, but I was too weak to challenge Charley and I did not trust my judgment. It did not make sense because five days later we drove three hours to his parents' home. We picked Aunt Margaret up at their home because she was coming to North Carolina to be with us and take care of Nick when I was in the hospital with the new baby. My sister and father had driven her to Charley's parents home. I knew my sister was upset because I did not make an effort to come.

She started to say something to me, but my father said "Bernie needs to listen to her husband and he is a doctor." I cried and my sister walked away with her hands in the air. My family headed north to Fairmont, West Virginia, and we drove south to North Carolina. One week later Benjamin was born, and Aunt Margaret was there to visit and care for us. We went through the motions of being a happy family. I gradually started to slip into the abyss of depression. I fought it because I knew I had to care for my children because I was not sure their father would be there for them. I found it hard to live with my self since I did not go to the funeral. I had material possessions but lacked personal and family connections. I was not happy and I longed to return home to West Virginia. Charley would not hear of it and said that we had it all in North Carolina. I thought I needed to make the best of a bad situation so I worked on meeting everyone's needs except my own. I thought if Charley and the boys were all right, then I would be fine. I cared for everyone except me. I think what saved me was a part-time position as a clinical instructor at Forsyth Technical Institute. The job helped because I liked being involved with the students. The involvement was satisfying and helped my wounded self-esteem. In a way the position helped me care for my self by giving me a sense of fulfillment. I liked being a mother to two little boys, but longed for my mother to be there to share motherhood secrets with me. Aunt Margaret was there as a sort of substitute grandmother, but it was not enough for me. I wanted to be connected to my extended family. It seemed as if I was growing increasingly isolated in North Carolina. I begged Charley to return to West Virginia. We argued about this whenever I felt he left me alone for long periods of time. I never wanted to argue like my parents, but finally I was challenging him and arguing.

In the midst of one of these arguments, he wrote a letter of resignation and placed it under the director's door. The director refused to take the resignation back. It was all Bernie's fault because he did not have a job. I believed it was my fault, too. Charley said that I did not make enough money. We had no where to go except back to West Virginia. Our family moved to Princeton, West Virginia, in December 1981, in the midst of cold blowing snow. It was cool and sunny in North Carolina when we left, but then I drove through the East River Mountain Tunnel and into a bleakness and snow. It was if I began a life of bleakness which only I could begin to remove. My life was bleak as I returned to West Virginia. I was the only person who could make it better.

Going Home

My life was bleak at times but my sons were always rays of sunshine. Individuals in the community would say, "there is the new Doctor and Bernie." My life involved making Charles totally comfortable. This was a bleak existence. I began to lose my own identity as an individual--that was bleaker still. I was totally responsible for raising our children, and my work schedule was adjusted to meet their needs. This still did not make his family happy. They kept saying that I was a bad mother because I wanted to teach nursing. They said that my work would pull me away from Nick and Ben. That was bleakest of all. I began working in Charley's medical practice, but it was not enough for me. It seemed like I was always doing his "dirty work." If he did not want to write a prescription for someone, it was my responsibility to tell them. I kept thinking I needed to ask him permission to take a teaching position at the local college. It was the female script I saw occurring in my family. He did not want me to work until he saw how expensive it was for him to buy health insurance for our family. He agreed I should take a full-time position at the college since family health insurance was a benefit.

A requirement of my instructor position was to work on my Master of Science degree in nursing. West Virginia University was bringing a program to Charleston, West Virginia, in the Fall of 1982. I worked at teaching and tried to be more attentive to the students unlike my actions in Parkersburg. I liked being a student in this master's program more than the bachelor's degree program. I was less attentive to Charles. Still I saw myself as being valuable in the marriage while having something to offer others. It was difficult for me to continue being the full-time parent. He could not parent because his patients needed him all the time. Everything seemed fine until he came home and said, "I will divorce if you do not quit your job at the college. My parents say you are leaving the boys in day care too much." I was devastated. I did

not think I could make it on my own. I said, “Well, ah, can I finish the year?” Charley retorted, “I guess so if you really have to continue.” I quit my position but fought to stay in school. He did not hassle me about school because he knew I could become a nurse practitioner. He thought a nurse practitioner would be valuable to him.

I went back to working in his office and was miserable again since I never did anything challenging. I ran interference for Charley with anyone who annoyed or bothered him. I did manage to complete my master’s degree in nursing. I kept abreast with what was going on at the college. I did everything with our children. He would say to the boys, ”I am sorry I cannot go with you, but daddy is a doctor and is very busy helping people. Mommy will go since she does not have a real job.” Mommy longed for a real job or at least some other sense of value. In 1986, the director asked me to take a temporary position as a faculty member. I said yes before I asked Charley. He was furious with me, but I was insistent because the boys were both in school now and besides, I told him, the position was temporary.

I liked teaching because it gave me a new sense of identity. Nick and Ben were doing well in school. They did not appear compromised by my working. I felt good about myself for the first time in a long time. I thought I was balancing my professional and private lives. I applied for the full-time position the next year. Charley was angry because I would not quit when he asked me to this time. This was a turning point in my life. I made a decision based on what was best for me. I started to live my own life, but I could not yet walk away from him. I believed I could not make it on my own with two children. I also thought my father would be so disappointed if I divorced “the doctor.” I was not strong enough to leave yet. As time passed, I established my professional life but realized my private life was a mess. I could not keep going on like this. With each passing year, I became stronger and could not care for his every need as I had once done. However he found someone who could assume this role.

Taking Back My Name

During the academic year of 1991-1992 my divorce was final, and I continued to live in the big Tudor at the top of the hill with my sons. The Tudor was a house but not a home. It was on the left at the top of a street that dead-ended to the left as the road made a sharp left turn. Only a small part of the back yard was flat because the rest of the yard took a sharp decline down a hill. In fact, the next door neighbors built steps to go from one part of the yard to another. Nick and Ben would walk their bikes to another street because of our location. The inside of the house had 5,000 square feet and included three levels. The basement had a large family room,

workshop, and garage. Charles wanted the basement so Nick and Ben could play there because of the noise and clutter they made while they played. There were problems with the house from the day we moved there. The contractor declared bankruptcy and made few additional repairs. The front foyer sloped oddly and there were roof problems. There were emotional as well as physical problems in that big Tudor house. I had never been happy in this house. I wanted a home I could manage with my physical and material resources. I did not want to be dependent on Charles, but I could not start a new life if he was always around my house. He established his separate existence but I could not.

Charles was always at my doorstep to protect his interest in the property. I really wanted to get on with my life, but he would not let me. The house was huge and out of synchrony with my new life. Since I was not interested in staying until Ben was eighteen, we placed it on the market but no one was interested. I could not seem to stop Charles from coming and going as he pleased, and I desperately needed to create a new environment for me. In April 1992, I purchased a smaller and older home in a quiet neighborhood near the library and within walking distance to the junior high. I liked the house because of the huge oak trees in the front yard and the large front porch with a swing. I thought I could become whole again in this house whenever I looked at those trees. Nick and Ben liked the neighborhood immediately. It was great for riding bikes, and they could walk to Boy Scouts. There was a basketball hoop in the driveway. It crossed my mind as it did many times before to move from Princeton because it was not my hometown but Charles'. I never could go through with the plans because Princeton was Nick's and Ben's hometown. Also I did not feel strong enough to make it on my own somewhere else. I could not manage the big Tudor by myself, care for my sons, and teach nursing. Charles reminded me of this constantly whenever he showed up at the house to mow the lawn or see the boys. Besides I was connected to the people I had worked with for five years. Although I was different now because I was divorced, I could not join in their conversations about husbands and men in general. So I made the lame excuse I could not move because Nick and Ben had "Princeton Tigers" imprinted on their chest. Plans were set in motion for Charles to move into the big Tudor and we would move to Hale Avenue in July. It was almost too easy to convince Charles to do this. I would learn later why it was so easy. I thought I was making progress in creating a new life when my father had a stroke on Easter weekend.

Nick and Ben were spending spring break with my father and step-mother. They seemed to thrive on Katy Road in Fairmont with my step-mother's family. Ben especially liked doing

outdoor activities like kite-flying, weenie roasts, and bike riding on country roads. Grandpa would take them to see the Pennsylvania relatives. Uncle Tom usually spent time with them and Aunt Terri would visit. I never quite knew what they did, but they always enjoyed their time there and hated to leave. Ben knew every country road and could direct me through the back roads and shortcuts I never could master when I lived in Fairmont. I was coming to Fairmont on Saturday to spend Easter with my family and pick up the boys. When I stopped at Tom's house on my way to Katy Road, he met me in the driveway. Bernie, dad is sick in bed and Peggy thinks it may be his diabetes. He will not go to the hospital. Peggy says that he will only listen to his nurse Bernie. I arrived on Katy Road to see the boys in the yard helping Alan, Peggy's son-in-law. Ben tells me grandpa is sick in his bedroom. I walk into his room and say, "Hi, Dad!" I take one look at his face and know he has had a stroke. He is very angry when I call the ambulance to take him to Ruby Memorial Hospital in Morgantown. Peggy and Alan ask me if I am sure. I am sure, and I feel awful inside like my world is crashing down around me. The boys stay with Peggy's niece while Tom, Peggy, and I go to the hospital. It is very late Saturday when it is confirmed he had a frontal lobe cerebral infarction. Peggy and Tom say how intelligent the family nurse is. I take no comfort in this. I am so very sorry for the times I bothered my father with my personal problems. I feel bad because I could never make him understand why "the doctor" and I divorced. After talking to the neurologist, I know he will never be able to make the four- hour trip to see my new home. Tom, George, Peggy and I stay into the night until the staff sends us home by saying dad is stable. My family spends Easter at Ruby Memorial with Dad while I must go back to Princeton because Nick and Ben have school. It will be difficult to get someone to cover for me. My dad asks where Charles is, and I remind him Charles and I are no longer married. I softly kiss him goodbye and hug Tom and Peggy. I return to Fairmont to get the boys, and we head south on Interstate 79. I am numb inside and realize I am not hearing Ben who is sitting in the front of the car with me. Ben insists on sitting up front and Nick usually relents quietly. Ben says that he noticed that grandpa had trouble reading or seeing the control knob on the radio or temperature control in his Subaru. I think dad has been having problems for awhile with transient ischemic attacks. This is the last thing I hear the boys say until we go down Flat Top Mountain and Ben remarks that northern West Virginia does not have any scenery as pretty as Flat Top. It is close to eleven when we arrive at the big Tudor house.

Near the end of the month, I sign the papers for the new house and make arrangements to move. Nick and Ben do not seem interested in packing--only moving. I began to separate our belongings of fifteen years of marriage. I pack what is mine to take to Hale Avenue. I call my Dad and Peggy every other day. Dad will soon transfer to Mountain View Rehabilitation Hospital. The stroke leaves Dad legally blind. He is having gait problems and going to need extensive rehabilitation. Dad will never drive a car again. I continue to go to work everyday and do my clinicals. Sometimes when I perform a medical routine in clinical teaching, it seems as if my spirit is somewhere else. I want to be present and involved with the students, but I am unable to do so. I want to be different but cannot find my way on this foggy road called life. One day in the hospital, a family practitioner says, "Bernie, you must be very proud of what you do." I say, "proud of what" with a puzzled look. "You should be proud of all those nurses you have a role in educating," he says. I think about what he is saying and know he is right. Yes, I am proud of what I do. The people with whom I have contact have sustained me over the difficult years. I need to find a better way to do this work which some people thought cost me my marriage. I can no longer live my life through my husband's life.

Graduation day for my student nurses arrives, and I stand in line with other faculty. I hug and congratulate the new graduates while the evening draws to a close. I put away my academic regalia for another year and vow to be a better teacher next year. The only problem is that I am not sure how to do this. I know I am in the process of discovering my own voice. I have been silent too long about my own needs. This silence has been with myself as well as with others.

As I prepare to set up a new home, I stay busy working on a diabetic education program at a local clinic, Mercer Health Right. I also cover for another nurse practitioner while she is on maternity leave. In June Ben turns thirteen, and both boys will be confirmed at the Catholic church. I believe I have a lot of things going well for me. This is why I will not quit my job and stay home and collect alimony like my older brother, George, advised. Then I find why Charles agreed to move into the big Tudor.

Charles is marrying a nurse we both have known for years. He is remodeling the big Tudor for his new family. I become very upset and feel like a total failure. I cannot get out of bed in the morning to go to Health Right. I am needed there, so I force myself to go. I begin not sleeping because I am totally numb and void inside. I remember there is Nick and Ben. Because Tom does not like the tone in my voice over the phone, Aunt Margaret and him make the four-hour trip for the confirmation services. It is Tom who remembers to bring the camera to take

pictures. I just sit at the reception and avoid people. I fear conversing with everyone because I cannot control the "wounded" tone in my voice. I notice Charles avoids Aunt Margaret and Tom. It hurts me that he ignores my beloved Aunt Margaret.

After the reception, Tom says, "Bernie you have to get it together for yourself and the boys." As Tom and Aunt Margaret leave, I promise him I will pull myself together. I make a list of what I have going for me. I have a master's degree in nursing and a job were I am respected. I am certified as a clinical specialist and a family nurse practitioner. These are the same credentials that were used in essence against me in my divorce. Ironically, because I have the credentials, I was not entitled to alimony. It also means I can take care of myself. Nick and Ben want to live with me. They are nice young men who were raised mostly by me. There is also my family in Fairmont who rallied around me during the holidays. I have been closer to them since Charles and I separated. Someday I want to get a Doctor of Philosophy degree. It is late at night when I look out of the kitchen window. Yes, I do have a lot going for me. First, I need to stop being identified as either the Doctor's wife or ex-wife. I feel stagnated and warped with this label. I decide to take back my maiden name to mark a new beginning and life for me. I would then be responsible for what happen to Bernadette Dragich. Finally I go to bed and sleep soundly for the first time in weeks

After supper the next day, I ask Nick and Ben what would they think if I change my name back to Dragich. Ben asks, "Will you have the same name as Grandpa and Uncle Tom, Mom? This is cool, Mom. Do we have to change our name?" I say, "You will still have your same name, but I will be Bernadette Dragich. Ben interrupts and says, "Stevie, our cat, needs to have the same last name as him." Ben makes some distinction that all the males in the family will have the same last name. I laugh and say, "Yes, Stevie will have the same last name as you and Nick." With a sense of hope in the future, I look forward to becoming Bernadette Marie Dragich again. I anticipate tomorrow so I can begin the process of recapturing my essence. It has been along time since I have had any sense of anticipation.

I begin investigating what I need to do to change my name. I talk to people about it but am asked why am I doing this since I have children and it will be confusing to them and others. My enthusiasm is lessened because I feel guilty as a mother. Tom tells me to do what is best for me. He reminds me if I am alright, then Nick and Ben will be fine. I really cannot make a decision. There is a voice within me that says I should not listen to what others say or think. I need to think and act on what my heart says is right, but I still cannot make a firm decision so I

concentrate on moving into our new home since school has ended. I begin working as a nurse practitioner at the Mercer County Health Department. We move to Hale Avenue and Charles' wedding draws closer. I have to make a decision about my name.

While cleaning my basement in my new older home, I break a window I try to open. I start to cry because I am alone. I am sorry for myself because I do not have a man in my life. My sons come running to see if anything has happened to me. They say that we will fix it together. We get the plywood and board up the window. The next day I order the replacement pane. It is decided--I go to Bluefield to the Social Security office to change my name on my social security card. The clerk asks if I just got married. When I say no, I sense she is puzzled. I proudly say that I am taking back my maiden name. The next day, I go to Bluefield State College where the department's secretary types up a memo for the personnel director. It states to please note the following name change. I will be known from this day forward at college as Bernadette Marie Dragich. Thus, I proudly begin to use the name that embarrassed me as a child.

I travel to northern West Virginia in late July as a form of renewal. I decide to take Nick to Cooper's Rock State Park about ten miles north of Morgantown. Nick wants to see a landmark that he read about in West Virginia history. I need to go to the look-out and see the Cheat gorge. Nick and I walk down a rocky path until we come to the look-out. As I look at the trees and rocks and the flowing Cheat River, I know I am finding my own voice. I will begin, as Bernadette Marie Dragich, to define my self again, through connections to family, friends, and students. As we head back to the car through the woods, I am at peace because I am in charge of my own destiny. When we arrive on Katy Road, my dad asks me again why Charles and I divorced. I tell him again that Charles is remarried to someone else and I am reconciled with this fact. I do not have the tears in my eyes I have had so many times before when talking to him about Charles.

Awakenings and New Beginnings

Henry Wadsworth Longfellow said the "holiest of holidays" are the ones we celebrate "in silence and apart." He called them "secret anniversaries of the heart." In August of 1993, I experience a silent moment that leaves a mark on my life. This silent moment is a "secret anniversary" I acknowledge every year. It is a turning point from the past to a new future. In early August, I am driving back to West Virginia after a family vacation. It is after eleven at night. We went through the first of the two tunnels between Wytheville, Virginia, and Bluefield,

West Virginia. Ben sits in the front passenger seat and Nick is in the back. They are sleeping or at least have their eyes shut. I am driving near Bland, Virginia, coming down a hill with rain beating on the windshield. The sky around the mountains is a wonderful dark blue. Fog and a faint blue hue frame the top of the surrounding mountains. It is then that I realize I am in pain. I am not happy with my life, and I need to do something about the direction it is taking. I am divorced and supposed to be in charge of my destiny. I need to leave this state of limbo I am existing in and climb the mountain. The rain is misting and the sky is still very pretty. I realize then that I am glad I am alive. It is better to feel pain and be awake to my surroundings than to be numb inside and asleep.

I let my former husband's marriage bother me. It may not be his marriage entirely if I am truthful with myself. Maybe I got caught up in traditional life scripts. My script is not working out like I think it should. As I fumble through the end of the academic year, I tell everyone that I want to go back to school. I talk of creating a new life but have done nothing about it. I need to redefine or improve my role as a nurse educator because then I might be a better person. I have spent the whole year stating I wanted to go back to school. When I start to do something about it, I do not follow through. I use my free time looking for another relationship, not a very productive activity. I get distracted and find little time to follow up on going to school. It becomes important for me to try and find another relationship so I concentrate on my social life rather than on my professional life.

I spend every weekend with a girlfriend at a local country and western club. Every Friday I procrastinate when Janice calls but go out anyway. Janice worked as a receptionist at Mercer County Health Department when I was a nurse practitioner there. Her husband decided he did not want to be married anymore. We go out most every weekend. I do not like it but talk constantly about wanting companionship. Another friend, Cynthia, wants to fix me up with her father, Alan, who is divorced. I like Cynthia and think that since she is nice her father must be nice too. I agree to meet him, and I ask few questions. He is very nice on the phone. There is one small problem, Alan says that I need to come get him for our date. Oh, okay, Why? Alan continues, "Well, Bernie, the State of West Virginia has my driver's license until 1995." He never comes out and tells me he is an alcoholic. I ask Cynthia. She says, "Bernie, you can help him." Alan is nice, but I know a relationship with him would be harmful for my psyche. I extricate myself, I hurt Alan, and Cynthia is upset with me. I am not proud of myself.

On a particular rainy night I am experiencing pain over my actions and behavior and not the numbness that was with me. I have been existing in a dream world. It is as if I am not awake to my surroundings--only a routine to all my activities. I objectified people and routines. I lack spontaneity or passion in my work. I feel pain because I do not like how I spent the year. I am coming out of a "fog-like" non-existence. I need to do something to create a change in my life and do things with passion. I decide I would go back to school so I could learn to be a better teacher. If I am a better teacher, maybe I will be more secure in my identity. I am going to follow through on my application to graduate school in the morning--I have been too indecisive.

I applied at Virginia Tech several months earlier but did not follow up on my application. I am scared of trying something new, and I thought I was too old to go back to school. I need to pursue the application, and I did not know where to begin. I tell my colleagues I want to become a better teacher and my work is an important part of my life. I became a nurse educator because I had a lot of clinical expertise and the right degrees at the right time. Someone in my past told me to teach the way I was taught in nursing school--so I did. For the most part, my education was oppressive. I am not happy with what seems are oppressive practices, yet I continue being content driven and rigid in classroom practices. It is with the passage of time I see the potential for more, so I begin to question what to do. These questions lead me to be more interactive with students. I begin to concentrate on the process of knowledge acquisition for students. I know being so content oriented overloads the students. I begin to value being in the clinical area with the students because I like the interaction with them. This interaction helps emphasize the process of knowledge development. I need to understand more about teaching and learning. I explore doing something just for me. I want to be a better teacher. I want to develop my mind. I explore my options and I talk about what I want to do.

At this time, I had a colleague, Elizabeth, who is a graduate student in the College of Human Resources. She asks, "Why do you want to get a degree in education, Bernie? That is not a real degree." She never says why she thinks it is not a real degree. I begin to doubt my intentions. Then I question my doubts about graduate school because I remember something. Elizabeth and I looked into her program before she started school. I never quite figured how this happened. We go to Blacksburg for an interview and take the Graduate Record Examination. Elizabeth tells me that she does not think she is going to school. I decide if Elizabeth is not going, then I am not going. Before I know it, Elizabeth is registered and taking classes. I mentally go "wait a minute?" I tell her I thought we were going to do this together. She

mumbles something about how I need to take care of my children, “It is your fault, Bernie.” As I say that we were going to do it together, she walks away from me. She is not listening to me. I forget about going to school. Elizabeth is supposed to be my friend, instead she makes me feel guilty about my children. Now a couple years later, she is questioning my desire to get a degree in education. I see no reason to put credence in her comments. I am going to pursue this, I just do not know when I will take the first step toward it.

After the episode with the rainy night, I decide I need to make myself follow up on the application. I call the education department at Virginia Tech and talk to Dr. Weber. I was told Dr. Weber handled the “nurses.” Dr. Weber is very nice on the phone, and I stumble over my words several times. He explains the process for taking a course on a provisional status. He is not taking new advisees because he will be retiring soon. First, I need to get into a class for the fall semester, then I will be assigned an advisor. He suggests that I talk to Dr. Wildman about the college teaching course. At this time, I am in a panic because I was talking to people with Ph.D. degrees on the phone. Dr. Wildman says that his course is an advanced level course. Maybe, I should take Advanced Educational Psychology with Dr. Burton first. By this time, I need to go to Blacksburg so I do not talk someone else just on the phone. I am disappointed but realize I need to be admitted first.

I drive to Blacksburg not knowing exactly where to begin. I start at the graduate school at Sandy Hall. A nice lady on the second floor directs me to the Curriculum and Instruction office in War Memorial Gym. Stupid me, I never ask her where in the building to go. Did I really want to go through with this? There are huge butterflies in my stomach. I walk around the circle twice before I actually go into the War Memorial Gym. I take a deep breath and look at the directory, but I do not see any listings that are familiar. I assume I need to go to the Education office. I walk down a long hallway. There are some bathrooms and the Instructional Technology Laboratory on the left. On the right there is a long window that looks into the swimming pool. There is a bench near this window. Down the hall from this window is the Education Office. I cannot bring myself to go in and ask for help. I stand by the window and watch people in the swimming pool. I need to do something about my application. It is now close to three o’clock on a Friday afternoon. I make myself go in and mumble something to them. The staff member responds, “Oh, you need to be on the third floor. You should speak to Bonnie or Barbara.” I guess I looked clueless so they tell me how to get to the third floor. Barbara is not at her desk so I walked down the hall. At this point I have nothing to loose.

Besides I can escape down the nearby stairs. A dark haired, thin lady is busy at a computer. There is something on her desk that has Bonnie written on it. She smiles at me when I said, "Hi!" I am immediately less nervous. She helps me with the application. Now I can take it back to the Graduate School. She even offers to help me register for the Educational Psychology course. When she checks, Educational Psychology is filled. She explains how I need to "force add" the course. Bonnie tells me, "You need to talk to Dr. Burton and his office is in the Instructional Technology lab on the second floor." I knew the lab was near the office I had been afraid to go into earlier.

I go back downstairs and stand outside of Room 220. What would I say to Dr. Burton? What will I do if he will not let me in the class? I just could not go through the door. Was I suppose to knock or walk through the door? I go back and sit on the bench to see what other people do. It is several minutes before a guy goes through the door. Maybe it would be alright to go through the door. I mustered my courage and enter Room 220. The first door on the right is open, and the nameplate said Burton. He is not in his office, but the computer is on. I flee to the parking lot. I get in my car and drive to downtown Blacksburg. I sit in a small café named Gilley's and just watch people go by. Drinking coffee and eating an oatmeal fudge cookie, I stare aimlessly out at the street until I know the offices at Tech are closed. I say to myself that Nick and Ben will miss me so I get in the car and drive back home toward West Virginia. I follow Main Street until it comes to Route 460. I turn right toward Pembroke. On the way home, I block everything out of my mind so I can go numb again. It will not work because I am feeling pain. I let fear of the unknown overcome me. Why am I so afraid of pursuing my education? If I am afraid to talk to the professors, probably my nursing students are afraid of me. When I arrive home, Ben comes down the stairs and asks, "Mom, are you an official student at Virginia Tech?" I am too embarrassed to give him an answer. I respond, "Ben, I need to start dinner. Are you guys hungry?" Ben says, "Mom, you did not answer me!" I respond, "I needed to talk to the professor, and he was not in his office." Ben continues, "You are going back again, Mom, right?" I answer him, "Well, I guess so but I should not be away from you and Nick." Ben still continues, "Mom, Nick and I can take care of ourselves. Another thing Mom, you are always telling us that we should not be "quitters," and you should not be a "quitter." Wanting to get Ben off the subject, I question Ben, "By the way, where is Nick?" Ben is very persistent in any discussion and responds, "Nick is at the library working on an

assignment. He said that he will walk home. Nick is fifteen and you do not need to worry about him." I answer, "I am not worried, Ben. I am just asking where he is."

I start dinner and stare out the kitchen window at what I call my "English Garden." I started this flower garden last year. It does not appear to be much, but it is my flower garden. It consists of roses, daisies, verbena, hollyhocks, columbine, herbs, and peonies. I planted this area because it felt good to dig up the earth. This garden guarantees I will always have roses to enjoy. I do not have to wait to get roses from someone else. The peonies remind me of my mother and grandmother who loved peonies. Peonies are a remembrance of the time I lived in Pennsylvania. My grandmother and Aunt Margaret had peonies in their garden. The daisies remind me especially of Aunt Margaret. They are her favorite flowers. My mother loved peonies, but we never had them in Fairmont. Mom regretted never having peonies in Fairmont. I do not want to have any more regrets. This is a time I want to recapture--the time of youth and new beginnings--a time with so few decisions made or thoughts of starting over again. This past spring the first peonies bloomed in red, white, and pink. I was very pleased with myself. Each vase of peonies brings back fond memories of my mother and grandmother. I want to begin again, but I do not know why I am so afraid. Nick comes into the kitchen and says, "Mom, I talked to Ben." I cannot even get words out to ask him about his day. "Mom, we will be fine and you should take that class. You need to go back and sign up as soon as possible." I respond, "Nick, we will see later." Nick replies, "Mom, I am telling you that you should go back." I do not have much to say. I let Nick and Ben eat in the upstairs den. I want to be by myself. Janice called to see if we were going to the club. I tell Janice, I should stay with the boys. Janice responds, "Bernie, it will do you good to get out tonight." I reply, "I was in Blacksburg most of the day," but Janice continues, "Bernie, your boys are big." I relent, "Oh, alright I will go for a little while."

The club is very crowded and filled with smoke-filled air. Janice is asked to dance right away. The band is playing Achy-Breaky Heart. I sip on a Coors Light Beer and think about being in Blacksburg. I cannot believe how I was so afraid and kept walking around the drill field. I really do not like being at this bar. After awhile, my eyes begin to water from the smoke. I keep coming here with Janice. I am looking for someone to want me. If they want me, this will affirm my self-esteem. Then I remember looking at my roses, peonies, and daisies. I need to make things happen for myself. I depended on a husband to make me happy, it does not work this way. Janice utters, "Bernie, you look like you are a 'thousand miles away.' I want to

listen to the band for a half hour or so and then we can leave." Janice is tapping the table to some "two-step" music when someone asks her to dance. Usually, I do not like being left at the table by myself, but it feels good tonight because I need to think about the direction my life is taking. We leave at 11:30 p.m. because I insisted. I tell Janice that I do not want to leave the boys alone too long. This is a half truth because I have left them before for longer. When I get home my eyes are watering, and I do not go directly into the house. I walk to the side of the house by the kitchen window to smell the roses. I hear Nick and Ben talking from the upstairs den. The light over the deck shines over the yard. Stevie, our black and white cat, is sitting in the window. Stevie starts to meow loudly and Ben looks out the window and asks, "Mom, what are you doing out there?" I respond, "I am smelling the roses." Ben continues, "Well, okay did you have a nice time? Stevie misses you." Then Tara, our little brown dachshund, barks. I go inside the house and Tara runs to me as Ben comes downstairs and says, "Mom, you are going back to Blacksburg on Monday." I answer, "Well, I guess so," and then I take Tara outside and Stevie follows. I get to smell the flowers one more time. My flowers! I do not have to wait for someone to give me flowers. Maybe I can go back to school again. I lay in bed that night and looked out at the big oak trees in my front yard. I just need to get to Blacksburg early on Monday to take care of things. I can do this. I can do anything once I put my mind and heart to it.

I am very nervous on Sunday. Nick and Ben ride their bikes on Sunday afternoon. Monday morning comes quickly. The boys help me carry the garbage to the curb. They gather their backpacks. I pick up my briefcase and the large blue textbook of Medical Surgical Nursing. I drop Ben off at the Junior High. In unison, they say, "Mom we'll be fine and you need to go to Virginia Tech for class." I say. "Oh, alright." There is one problem, though. I have not finished registering for class. How am I going to do this? This is the question that is on my mind while I drive. I leave the junior high and drive to the high school. Nick tells me not to worry about him. He is going home on the bus that stops at the junior high. Then he will walk home after finishing his homework at the library. Nick assures me, "Mom, I can mess around when I come home." He waves good-bye and says, "Good luck!" I leave the high school and turn onto Courthouse Road. The nursing home is on the left side of the road. A twinge is in my heart when I pass the nursing home. I equate the nursing home with my former husband and his current wife. He is the medical director and she is the nursing director. This twinge or pain makes me determine to overcome my fears. I continue driving until the road intersects with 460.

I drive toward Bluefield. I admire the large oak tree in the median near the access road to the landfill and animal shelter. The community wants to save this oak tree when the state widens the road next year. Shortly I pass the mall on the right and go through the light. As soon as I cross the bridge, I turn the car right and proceed into Bluefield. This road follows the railroad tracks and is not very attractive. The railroad makes Bluefield seem dull, but Bluefield is not a dull town. I go to the hospital first to make clinical assignments for my Tuesday clinical group. After reading patient charts, I make assignments for eight, third year nursing students. I cross another bridge near the railroad tracks and proceed to Dickason Hall. By this time the only available parking place is near the soccer/baseball field. It is ten o'clock before I arrive in my office. My office is on the third floor with the other associate degree nursing faculty. The other members of our division are on the fourth floor with the secretaries and the division chair. Our offices are in a nook near the main engineering technology offices. Since this wing is very drab and dark, the college has tried to brighten things up with a terra cotta paint. It helps some but not a lot. If you look out one of the few windows, all you will see are automobiles and railroad cars. On Monday the hallway is crowded with nursing students and engineering technology students carrying drafting and surveying material.

I spend Monday at Bluefield State College in my office. My chairperson calls me to see if I registered at Virginia Tech. I pause and tell her not yet. She asks, "Bernie, what is the problem?" I respond, "Well, uh," the words will not come. There is a long pause. "I will take care of it this afternoon." I leave Bluefield State early that afternoon. I stop in Princeton to see if the boys are home. Actually I am double checking myself. Did I leave enough telephone numbers on the bulletin board? I collected a list of friends they can call if I am not home. Is there enough food? Is it easy to prepare? I am not sure why I am worrying about food because Nick and Ben can both cook. They cook when they go camping with the boy scouts. I realize I left money to order a pizza. I take the dog and cat out and make sure they have food. I lock the door and take a deep breath on the porch, get in my car, and pull out of the drive. I am near the West Virginia Visitors' Center and think about turning around and heading home. I stay on the road and know I will soon need gas. If I stop I may not continue. I drive to Glen Lyn and stop at Little Mac's near the power station. I am out of West Virginia now! There is no turning around now! My next stop is in Pembroke at the Dairy Queen to get a cup of coffee. I stare aimlessly at the coffee. George Strait music fills the dining area. People talk about going to the Cascades for a picnic and hike. I say to myself that I cannot continue to waste time like this.

I arrive in Blacksburg and notice it is very congested around the circle. I park my car in the commuter lot and walk toward Memorial Gym. I repeat to myself that I can do this, I can do this. I walk through the gym and up the stairs to Room 220. I go in the Lab and look in his office, but Dr. Burton is not in. I do not ask anyone for help. I sit at the bench near the window that looks down at the swimming pool. What will I do next? I go to the third floor and ask for Bonnie. She was so nice and made me feel comfortable. Bonnie is not at her desk but Barbara is here. I speak to Barbara, "Excuse me, I am Bernadette Dragich and I am trying to register as a provisional student." She smiles and is quite friendly. I am immediately at ease. I listen as she explains what I need to do. I am not afraid to show her how ignorant I am about the admission procedures. I am not exactly sure what happened next. I stayed that day--whatever Barbara said made it easier to stay. I am glad the classroom is near a pay phone. I call Nick and Ben before my class starts. I am still anxious because I need to "force add" this course. I pace the long hallway. I avoid the security students at the desk near the vending machines. They are asking to see student identification cards, and I do not have one. I am anxious about the "force add," and I do not need to worry about not having identification. I finally walk in the classroom at fifteen minutes before seven. I make the third person in the room--there is one guy and one girl. I am old enough to be their mother. The guy tells the girl that he needs to get Dr. Burton to sign his "force add" sheet. I immediately am relieved because I am not alone. During the next fifteen minutes, the room fills up. A couple of people bring chairs into the room. The last person in the room is a man wearing jeans and sneakers. He places a folder on the desk and says that this is Advanced Educational Psychology and introduces himself as John Burton. The guy next to me jumps up with his slip and shows it to Dr. Burton. I am right behind him and a line forms behind me. He just quietly signs our slips. I sit down and breathe a sigh of relief.

I am comfortable now. I took that first step. People are very nice. It will be nice being in a community of learners. It is near ten o'clock when class ends. They are asking to see the identification cards at the desk. I follow everyone else and ignore the people asking for identification cards at the desk. I continue walking. I feel as if I belong. It is dark outside. I need to cross the drill field and find my car. After starting my car, I head toward the coffee shop. I savor the smell of the roasting beans in the shop. There is not a smell quite like this in West Virginia. I take a deep breathe outside the coffee shop while holding my coffee latte. I leave the parking lot of the coffee shop and follow Main Street until it intersects with State Route 460. I turn right and head toward West Virginia. When I leave the stretch of highway

that is part of the Jefferson National Forest, I notice the sky near the mountains is a foggy blue. I see this as positive sign of a new beginning.

There are a few tractor trailers near the intersection of Route 460 and Interstate 77. They are in the turning lane for Interstate 77 South. The city of Princeton sits to the right in the slight valley. It is a maze of twinkling lights from the highway. Main Street is deserted. I turn right near the post office and Methodist church. The boys left the light on the front porch. As I unlock the door, the cat heads out the door and the dog's tail is wiggling. I pick her up as I call for Nick and Ben. There is no answer. Their backpacks are in the foyer. The television is still on downstairs. The local news is ending and The Tonight Show is beginning. I run upstairs. Ben is sleeping. Nick is in bed listening to music. He asks, "How did it go, Mom?" I tell him, "I am in the class." He says, "Mom, I am glad that you are going." I reply, "Nick, you better get some sleep." "Goodnight, mom." "Goodnight, Nick." I go downstairs and walk the dog. I notice there are dishes in the sink and crumbs on the kitchen floor. The stove is clean. I tidy up the kitchen before going to bed. I do not mind doing it tonight. I am wide awake--today is a day of beginning again.

Charley is remarried now and I am single. I am glad I am single because I learned to care for myself. In the process of caring for myself, I found it is important to value what you do. I am glad I had my professional life and the contact with the students over the years. My professional life helped me develop into the person I am now. I had people tell me I should have stayed at home and collected alimony. If I had done that, then I am sure I would not have my own identity now. I would be someone's ex-wife or first wife. Now I am Bernadette Dragich and am proud of who I am. I wanted my dad to understand this before he died. I became more secure as a person. It was not important he understood, but it still hurts that it bothered him.

I believe when I was true to myself, then my perception changed. It was easy to understand how my past and present shaped me and my future as well as my former husband. Education was stressed in my family, since circumstances prevented my parents from further schooling. The more education I received, the more I questioned the female and male roles in my life. With time, I have come to understand how things were scripted for Charley as well as myself and why our marriage did not work. I have come to question how society can put doctors on one level and nurses on another. Nurses and doctors are just one example of this hierarchy. Maybe the thoughts of this hierarchy has led me to question my own practices that may lead to oppression of others. When inequality is created, there is oppression. If oppression is not

recognized, then it is difficult to care. It is from the scripts we lay out for people that lead people to behave in a certain manner and for others to respond in a certain way. It becomes important to be true to yourself and not assume what appears to be the dominant societal role. It is the creating of this inequality and the response to it that devalues caring and makes it invisible. I realize I was oppressive toward my beloved Aunt Margaret. At the same time, I am glad she came back in my life. That was a turning point that was invisible to me for many years.

Chapter Two: Caring Concepts

Chapter one discusses the significant moments of my experience from which I derive an understanding of caring and its conflicts. Reflection is educative and allows me to incorporate new and past experiences to refine a personal philosophy about caring. Fisher and Tronto (1990) say that caring is naturalistic and rises from individual motivation. It is social interaction that involves conflict, and often revolves around resource allocation. The social, historical, and political contextual elements of caring are examined in this chapter within a nursing and feminist framework.

The American Nurses Association's revised Social Policy Statement calls for "the provision of a caring relationship that facilitates health and healing" (ANA, 1995, p. 6). They define this caring relationship as an essential element of contemporary nursing practice. Caring is the essence of nursing and the profession's moral ideal. To understand what it means to care as a nurse, the care phenomenon is examined from a theoretical perspective.

The Phenomenon of Care

Heidegger (1962) sees caring as a natural way of existing in the world, and Roach(1987) sees caring as the most basic mode of being. As an important component of the helping professions, the Hebrew and Christian cultures say caring is an essential for healing the sick (Gardener, 1992). Care comes from cara, which means 'anxious, exertion' and 'carefulness and devotedness.' Care means concern for, commitment to another and attending to others (Partridge, 1958). Currently care has many uses. The media urges us to care for the environment, care for our family and friends, and emphasizes caring for ourselves. Commercials promote health care facilities as caring. They deem caring is essential for health care workers, social workers, teachers, and others.

Leininger (1988) states that the word "care" has been used for more than one hundred years without being defined consistently. She states that many have equated care with nursing. Yet, caring is essential in all our lives. Leininger (1984) differentiates between generic care and professional care. She sees generic care as "that assertive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated need to improve or improve a human condition" (Leininger, 1984). Professional caring is seen as "those cognitive and culturally learned behaviors, techniques, processes or patterns that enable an individual, family, or community to improve or maintain a favorable health condition" (p. 5). A closer scrutiny of

the American Nurses Association's Social Policy Statement (1995) validates that professional caring involves cognitive goals and processes that meet the health care needs of patients. A precondition for professional care is sense of natural or generic caring. Sara Ruddick (1984, 1989) describes this intuitive sense of caring as maternal thinking. Maternal thinking as a discipline in attentive love stimulates the preservation, growth, and the acceptability of children. Mothers learn strategies through practice that help keep children safe and enhance their development. Ruddick (1982) says attentive love is a voluntary practice that validates the reality of the situation from a child's world view.

Ruddick (1989) sees attention as the capacity for empathy--the ability to suffer or celebrate with another out of a sense of understanding of the person's situation (p. 122). A former student told me about her experiences working on a skilled nursing facility. She uses attentive love while providing nursing care to her patients and attempts to understand their experiences and how it affects health. Preservation is displayed when the nurse helps the patient in compensating for the impact of illness and helps the patient in maintaining a state of health. This involves counseling and teaching the patient so he or she can live in their home environment. For this particular nurse, it means trying to walk her stroke patient to the bathroom every two hours to improve bladder tone and prevent "accidents." She says that placing a diaper on a patient is far too easy. She tries to do the same tasks that she delegates to others. She gets to know her patients, and she feels connected to her staff. This nurse feels that she role models how she wants them to be with their patients.

Ruddick (1982, 1989) describes how mothers think through situations and develop strategies to meet the demands of children. She also states conflict will occur between the preservation and growth of children. Nurses assess patient care situations and decide which strategies will enhance the well-being of patients. Benner and Wrubel (1989) define care in nursing as the alleviation of vulnerability and promotion of the well-being of patients while dealing with illness. A nurse may experience an incongruence with personal needs of the nurse and the needs of the patient. Ruddick stresses that we must acknowledge the separate selves of patient and nurse. This acknowledgment prevents the nurse from being overwhelmed by patient care needs. Ruddick (1989) says that the third demand of children is training to become an acceptable member of society. The nursing emphasis in this area is the patients' assistance in the achievement of a sense of well-being when dealing with the threat of illness and disease.

Allen and Walker (1992) use Ruddick's theory while exploring how care giving daughters' meet the demands of aging mothers. They conducted in-depth interviews with twenty-nine care giving daughters. All daughters lived with or within a forty-five mile radius of their mothers. The investigators used the theory of attentive love as a guide through the data analysis. The authors examined the vulnerability of the frail mothers that required care giving. Their study involved the promotion of independence of their mothers and the prevention of further losses related their frail health. The authors emphasized the cognitive aspect of caring work rather than caring tasks. They examine how cognitive processes of caring are grounded in experiences and relationships. Allen and Walker (1992) stated that they best view family care giving in a relational context. This view allows one to see the unique opportunities and constraints when they give care to another. The authors stress the importance of considering the perceptions and experiences of the caregiver and the tasks of caring work. The daughters in the study had relationships and attachments beyond caring for their mother. These relationships may be a source of conflict for the daughters.

Nurses work toward the promotion of autonomy and prevention of loss in their patients. The cognitive thinking examines the uniqueness of patients and works toward the well-being of each patient. This process must consider the attitudes and values of the nurse(s) involved with the client. A closer examination of professional caring shows that activities and attitudes are essential elements in a caring practice. Griffin (1983) defines caring nursing activities as "assisting, helping, and serving that are mediated through the nurse-patient relationship" (p. 291). She elaborates that this relationship connotes more than an institutional performance of duties. She states that it involves assessment that requires recognizing the patient or student as a person. The relationship suggests a sense of connection and a way of being with others that energizes caring actions. Nurses need to examine the meaning behind their actions. This examination allows nurses to see what is morally ideal and valued. In the same sense, caring is confirmed and discussed within the nurse-patient relationship. This relationship unfolds during health assessments, health teaching, during physical care, or whenever they show concern for a client. Nursing knowledge directs nursing actions, but the feeling of concern or just being gentle makes those actions caring. Sally Gadow (1980) sees caring as supporting an individual client's meaning of reality.

Benner and Wrubel (1989) see caring as understanding the meaning of the illness for the patient. The authors stress the importance of understanding how the illness interrupts the

patient's life. This understanding guides the nurse in seeing the patient in context. This context shows how each patient has a unique interpretation of health and illness. They learn this process in clinical nursing courses. Students learn to appreciate individual contextual elements and learn to "think on their feet." An appreciation of this interpretation leads to an intuitive sense about the patient and a moral sense of reasoning. I see this moral sense as nurtured while one is in a relationship. The following vignette is an example of how this moral sense of reasoning begins.

He is sixteen-year-old with a feeding tube and a venous access device. He has lost thirty pounds in the last six weeks. After several weeks of tests, the doctors know he has a neurological impairment with a poor prognosis. His mother is a nurse and she is always at the bedside. After weeks of frustration, she is beginning to talk about the pointlessness of doing advance procedures. He is a talkative young man with a bright smile who is unable to eat and keep down solid food. However, he is able to enjoy a few plain M & M candies in his mouth by slowly dissolving the chocolate. As a nursing professional, I look at him as a patient, and then I look at his mom and dad. I wonder how hard it must be to deal with a sick child. Barry is a teenager and a mother's son and he is Cassie's patient today. These are factors to consider when thinking about what is morally right for Barry. Cassie is a beginning nursing student who has a son just a few years younger than her patient. Various relationships must be considered as we decide the best method to give this young man nursing care. He is not a textbook picture or disease entity. He has the same interest as an any other sixteen-year-old, but he is very sick. As Cassie gives him nursing care and talks to him and his mom, I arrange for one of my faculty members to bring him some plain M & M candies tomorrow. These simple candies are really important to him in this situation. It gives some resemblance of the ordinary and everyday to a very grave situation. We are not going to prevent further loss, but we may promote his autonomy through a few M & M candies.

Gilligan (1982) says that female moral reasoning or the ethics of care consists of three stages and two transition periods. In the first stage, emphasis is on self and moral issues surrounding one's own individual needs. Next, comes a transition from selfish behavior to responsible care that balances self and others. Decisions evolve around what one should do best in caring and connected relationships. In the second stage, the individual has a desire to care for others and show concern for other individuals. It is as if they equate goodness with sacrifice, and this stage is similar to Kohlberg's stage three. At the next transition, the woman sees that care of self is equally important as caring for others. It is important that the person be honest

with self and others. It is here that one becomes responsible for decisions that she makes. In the final stage, a morally mature woman develops when meeting her own needs are as important as caring for others. This person does not try to please everyone and recognizes that her own needs are an important aspect of social relations. This woman would not "use," hurt or inflict harm intentionally on another individual. This perspective is important for a nurse to learn, so as to more fully care when he or she is addressing another's personal needs. The mother of the sixteen-year-old exhibits these stages while she cares for her son and struggles with issues of care.

Sometimes an individual does everything for another person and fails to meet personal needs. My mother did this with my father and her children. My mother served my father constantly. I would do everything for my former husband and fail to do what was important for me. He did not ask me to be that way. I was trying to be the way I thought I should be. It was the script that I learned in my family of origin about women's work. I was in mid-life before I could more fully care for self. I see students study, cook meals, clean house, run to soccer games, and feel guilty because they are not doing enough for their children. I ask them, "What have you done for yourself?" It is okay to soak in a tub, see a favorite movie, or go out with your husband. Doing things for yourself allows you to energize your soul. If your soul is energized, then you can truly care for a patient when they need you to be there. If you do not care for yourself, then care becomes a burden and you resent the care that you give to someone. The care receiver will begin to resent their own caring.

Gilligan's (1982) In a Different Voice describes a moral development that addresses the conflict arising out of the need to care for others while deciding a course of action. Initially, Gilligan interviewed twenty-nine women who were facing decisions regarding abortion. The women were deciding what would be best for them and struggled with the fact their decisions may hurt someone. An extensive interview process examined choices, options, and conflict among individuals. The author studied how the decision affected the participants' sense of self and whether they thought that they had an obligation toward others. Individual choice centers on how a woman could care for herself, the prospective child, and others in her life. Gilligan (1982) talks of the formulation of truths and how this enables individuals to participate more fully in their experiences. These cognitive processes promote empowerment because it frees individuals from possible distorted perceptions and allows one to see connection with others. This set up the possibility for choice and growth in one's life. Nursing is contextual and nurses

experience struggles with the choices and decisions that they make. Nurses and patients need to understand this process to make authentic choices in health care. Similar to the dilemma in Gilligan's study, professional nurses reflect and relate to others while making choices that are in the best interest of their patients. Sometimes these choices may differ from the typical textbook procedure.

In addition, Gilligan completed a longitudinal study of twenty-five seniors in college and interviewed them five years later. The process centers on resolving issues and gives insight into the moral development of women. Lastly, Gilligan conducted "The Right and Responsibility Study" that was based on interviews of males and females between six and sixty years in nine age groups. Gilligan analyzed these interviews and examined the relationship of gender to the constructs of justice and care. She states that we must focus on women's moral difference rather than saying that women are morally inferior. Gilligan (1982) states that men and women may speak different languages, yet they arise from similar thought processes. It seems that they use the same words to encode different experiences of self and social relationships. Since the languages overlap in moral vocabulary, there is a propensity for systematic translation that creates misunderstandings. This process impedes communication and limits the potential for cooperation and care within relationships (p. 173). According to Gilligan, men see themselves as independent and objective while women view themselves as interdependent and responsible for others. This is why women do not do as well as men on Kohlberg's scale.

Gilligan (1982, 1993) thinks that women and men make contrary errors in their relationships. Men think that if they know themselves that they will know women. In turn, women believe that if they know other people, then they will know their inner self. Men build relationships that disconnect them from others, while women do not realize that they are moving away from their inner self. This leaves everyone with unresolved issues regarding care, power, and responsibility. I see these unresolved issues affecting the nursing profession. Do women care out of a sense of responsibility or because men have power over them? We can also state that nurses care because of a sense of responsibility or because of the power of the physician.

Brown and Gilligan (1992) examined part of this question when they studied caring and power orientation as young women approach womanhood. Is there anything that a young woman gives up as she approaches adult life? Brown and Gilligan (1992)state that one subject questions her parents' relationship and sees an imbalance of power (pp. 145-146). Other subjects reflect on the times their mothers use power with care and concern for them. Still, they

explore power issues concerning teachers and people of authority where they may abuse power. The authors fail to address if "power over" and caring create the subordination of women. Their findings suggest that women struggle with giving voice to their concerns. The women in their study wanted to be visible when others wanted them to be polite and unnoticed. These issues are relevant to the nursing profession. I see this occurring whenever a physician's decision or order is questioned.

Jean Watson (1988, 1995) echoes Gilligan and Noddings because she sees caring as relational and the moral ideal of nursing. Caring nursing relationships promote the protection and enhancement of human dignity. Human caring involves values, a will, a commitment to care, knowledge, caring actions, and consequences (Watson, 1988, p. 29). This involves the intentions and actions that transmit or convey physical care. Watson (1985) sees transpersonal caring as giving the patient a sense of security while a mutual beneficial nurse-patient relationship develops. She sees caring as a multidimensional process that includes the "ability to be present, to be reflective, to attend to mutuality of being, and centering one's consciousness on wholeness and health" (Watson, 1995, p. 51). This consciousness centers on the client's experience or perception of health and illness. The crux of Watson's caring theory focuses on caring elements which address elements of being within the context of the health care environment. This theory lends support to a knowledge base and clinical competence that help the nurse in understanding the human condition. These caring elements allow nursing to have its own language and release it from the medical model. They address a caring knowledge base that assists in develop a language that makes these elements of caring more visible.

Watson (1985) says these factors are applied after the patient expresses his or her needs. They address values, instilling faith-hope, the development of a helping-trusting relationship, creative problems-solving, teaching-learning, and existential-spiritual forces that are evident in the practical situation. Health care needs should be examined with care and reflection. This examination allows one to find hidden meaning within practical nursing knowledge. A nurse who cares from this perspective is aware of outside forces that may hamper her or his ability to care for self and others. He or she does not assume the superior attitude of an expert with the patient but promotes active and mutual participation with the patient.

I work in a pediatric practice as a family nurse practitioner. Sometimes, I have parents who do not want to see me. They say that they are paying the physician rate for an office visit and expect a physician. However, I have some parents who want to see me. The managing

partner in the practice says it is because I do more teaching. Still, I think teaching is just a small element of it. I try very hard to understand the parents' perspective and the child. A patient's mother is a part-time server at a local restaurant and a student in the vocational nursing program. Once when she waited on me at the restaurant and asked if I remembered her. She said that I treated her daughter and was very kind to her. She was coming back to see me the following Saturday in the office. I was not sure what I did that was of any significance. The physicians are very caring, kind and exhibit great patience. Still, I think that I really understood the mother's situation better than the physicians. Her daughter was a year old and had frequent ear infections with a very high temperature. She is a single parent who is trying to go to school so she will not always have to be a recipient of aid to dependent children. I provided care for her daughter in the latter context. It was more than just treating the ear infection with an antibiotic. I do not remember what I did exactly. She said that I listened to her concerns and that helped her stay in school. She was very frustrated about having a sick child, being a single parent, and a student. It is caring about the mother plus the baby. The mother is not my student but maybe she experienced my caring. Significant caring often occurs when the caregiver does not remember and the care receiver does.

I think you have to try to understand care to practice it. Individuals make nursing judgments and decisions because of the understanding obtained in relationships. Attentive understanding allows the nurse to examine someone's needs. It allows the nurse to be with someone rather than doing something to them. This was the central issue with my patient with frequent ear infections and her mother. A crucial element of care for the sixteen-year-old with the neurological impairment is how one interacts with him. The nurse's expressive elements of care must guide technical competence. I see an examination of caring as allowing both me and my students to uncover those elements that sustain care in this incidence.

The Concepts of Caring

An analysis of the concepts of caring allows nursing to link caring to behavioral outcomes. Morse et al. (1990) examine the concepts about caring in nursing. They state that caring should be more than an internalized feeling if nursing is a legitimate profession. Morse et al. found five categories of caring from the literature. These categories are caring as a human trait, as a moral imperative, as an affect, as an interpersonal relationship, and as therapeutic intervention. They identified the client's subjective experiences and physical responses as outcomes from these concepts of caring. Auditors and reviewers scrutinize medical records for

indicators of appropriate care. Are the client's subjective responses a part of quality assurance? Is there institutional incentive to care in health care agencies? Caring is still invisible and devalued. A closer examination of these concepts may yield answers to the above questions.

Tronto (1994) questions why so many treat caring so marginally when it is a common aspect of human life. Tronto says that race and class distinguishes who cares in our culture. Tronto suggests that society equates "taking care of" with masculinity and public aspects of care. Women and individuals of color, by contrast, care about private or home concerns. Further, they often care for the privileged in society. These individuals will hire women and people of color to care for their needs, such as childcare, house cleaning, and meal preparation. This caring labor allows them to pursue other efforts in their social or professional world. Tronto believes that society does not value this type of work since it is invisible and devalued. The caregiver does not value his or her work but defines his or her purpose by the contribution that he or she makes to the care receiver's life. Tronto (1994) says that care is devalued in society as work and is held in lesser esteem in our culture's value hierarchy. Caring is not valued in the health care setting where the caring that is done does not tie behaviors into quality assurance or receive reimbursement.

Tronto (1994) wants us to evaluate care from these elements: attentiveness, responsibility, competence, and responsiveness. Attentiveness requires that we define another's needs before caring for them. It also requires that we address our own needs while caring for another. This is similar to the assessment skills exhibited by the professional nurse. Tronto's next element of care is responsibility which is found in cultural practices, which have different meanings depending on gender, race, class, sexual orientation, and hierarchy. It also rests on what the person accomplishes or does not accomplish. A female is responsible for raising and nurturing children in a marriage. A female may feel she is to blame when a child is ill because she failed to meet the child's need in a timely manner. A nurse may impede a patient's recovery by failing to meet a defined health care or spiritual need. The health care environment may say that a patient need is specifically a medical need or a nursing need.

Martin (1994) addresses educational practice, concepts, and concerns that gender influences. Martin thinks that traditional theories of education do not emphasize care, concern, and connection with others. These issues arise from the productive and reproductive processes of society. Martin (1986) is concerned about the role of a liberal education where it is important not to separate self from others or split mind from emotion (p. 7).

In the chapter entitled “The Contradiction and the Challenge,” Martin uses Woolf's metaphor of the bridge between two worlds to emphasize the need to move away from detached objectivity and dualistic practices. This bridge separates the “female” or caring professions of nursing, social work, and teaching from the “male” professions. Why are there so few women in those “male” professions? Is it because they settled for less or that they did not believe in their abilities? Why must they live a contradiction if they make it to the top? Is it necessary for those who enter the caring professions to sacrifice self? What role does the hidden curriculum have in answering these questions? In exploring these questions, I have the opportunity to analyze Martin's concepts and to examine alternative modes of thinking.

Martin (1994) challenges society to recognize that family life is educationally significant and is gender constructed. The author states that education chooses “the basics” and the “basics” need to be rethought. The educational significance of family life comes from Martin's distinction between productive and reproductive processes in society. Martin states that the reproductive processes include child bearing, child-raising, caring for the sick and elderly, and managing a household. Martin sees the productive processes as including political, social, cultural, and economic activities (p. 207). Our society does not value or want to link the reproductive with the productive. The reproductive processes are the responsibility of both sexes, and for this to occur, the reproductive processes need to be brought into the public educational realm. This has not occurred because historically men have been given the responsibility for productive processes and females have the responsibility for the reproductive realm. Unfortunately, society evaluates traits differently when possessed by men or women. They chastise a female for being a “rational” and calculating business person, but they applaud the male counterpart.

Martin examines Rousseau's Sophie and Emile to gain an understanding of gender issues in education. To Martin, Sophie and Emile's story is significant but is either absent or not discussed in theory classes. Emile is [portrayed] to be educated as a citizen in the ideal state and the patriarch of his family. Sophie is [portrayed] to carry out the reproductive processes she will “inhabit home and not be qualified to venture out from it” (Martin, 1994, p. 65). Also, Martin raises the concern that maybe Emile's tutor is a manipulator and is operating from a “hidden curriculum.” Emile thinks that he is free while they are controlling everything for him. The answer is not to give Sophie the same education as Emile's because that is not considering who

she is as a person. History has treated Sophie by banishing her from texts or treating her superficially.

Martin states that both sexes lose when they exclude the education of women from the classroom. Women do not learn the value of their experience or their unique standpoint. Men learn not to value or appreciate the education of women. Education must not have a two track systems or a division of labor. The answer is not that a woman should endure a husband's wrong. Martin (1986) states that "education should seek ways of incorporating Sophie's virtues into the overarching ideal guiding the education of men and women today" (p. 9). Schools must value these virtues and create a "middle" position. Equal recognition does not mean elevating the caring professions at the expense of the "male" professions. An intelligent nurse does not need to go to medical school to receive recognition. An educated woman can still be a mother and a business partner. It is all right for men to care for children and ill family members. Martin wants to "redefine the long-standing value hierarchy that places the public sphere above the private, productive processes over the reproductive, and men over women" (Martin, 1986, p. 10). To Martin, the beginnings of change occurs with a new awareness that transforms negative ideas about women and what they do. This occurs when one realizes that removing the caring aspect when achieving a productive goal is not necessary.

Applying Martin's insights to my profession, I would say that nursing and women should not have the market on caring. Caring should be equally important to men and physicians. I was working in the pediatric office on a Saturday when several fathers brought their children in for "well child visits" and immunization. I thought of Martin's gender sensitive ideal. These fathers are young men who seem genuinely interested in their children. I think they want to be involved in their children's lives. When I consider this, I am filled with hope for the future. I see my own sons differently than their father because cultural norms and expectations are different. Also. I think that I raised them to be sensitive to the reproductive realm of thinking.

Martin (1994) applauds the women who refuse to "distance themselves from the interest and needs of their students, patients, and clients" (p. 114). I see several issues with Martin's statement. Sometimes, there are issues with your significant other and children that cause concern. These concerns make it difficult to be attentive to patients' or students' needs. It becomes very easy to distance yourself from the patient or student. When I was experiencing my divorce, it was very difficult to show presence to my students. By focusing on them, I was able to move beyond my personal problems. There are times when you must interact with

people who are very difficult to deal with because they are angry and try to make it personal. I think working on being authentic, makes it easier to show up and be there for that patient or student. I think Martin recognizes the importance of authentic presence. In order to maintain presence, the professional must care for self. This caring for self gives one the spiritual energy to be attentive to another's needs.

A gender sensitive ideal of caring recognizes the desire to care is human. Roach (1987) says that they must affirm the capacity to care and actualize. Roach sees the caring behaviors of nurses exhibited through compassion that guides technical competence. Technical competence requires compassion if the nurse is to be responsive to individual patient needs. Compassion and competence allow the nurse to be confident in his or her abilities. Tronto (1994) sees responsiveness of care as examining issues of vulnerability in the care receiver that requires nurses to balance the caregiver needs with the care receiver needs. This requires seeing the standpoint of the care receiver.

Tronto (1989) wants us to evaluate what caring means to society and the moral questions that it raises (p. 185). Tronto is attempting to address how privilege alters one's perspective. Those with less status develop a standpoint that includes reasoning through issues that involve excluding others because of status or class. She recognizes that care involves diverse positions and participants. She also criticizes Noddings for having a narrow sphere in which to evaluate care. Tronto (1989) states that when "Noddings says she will respond to the stranger at her door but not to starving children in Africa, she ignores the ways that the modern world is intertwined" (p. 182). Care should be more than women's work and is an issue that must be evaluated from multiple contexts that are relevant to health care and nursing. Privilege affects one's perspective within the health continuum. The physician may be more privileged than the nurse and the nurse is more privileged than the nursing assistant. These perspectives must consider oppression and how it influences caring. Caring work leads to a type of rationality that helps in working toward the best interest of others. If caring is to be valued, then it must be visible across aspects of human existence. Sometimes it comes down to how one handles the privileges that one is given. I think that if you truly use care to improve your thinking, then you will be sensitive to these issues.

Caring as a Human Trait

Caring is a human trait and an essential way of being. Roach's (1984) work on caring in nursing is similar to Tronto's ethic of care. Caring is a process which involves knowledge, experience, and skills. It requires continued practice and encompasses a sense of dedication to another and provides energy to achieved positive outcomes for the patient or student. Roach says caring is evident in five attributes that allow us to identify expressions of caring. These attributes are compassion, competence, confidence, conscience and commitment. Roach sees compassion as an awareness of our relatedness to others. This way of living gives spirit to the technological procedures in health care. Nurses need knowledge, experiences, and skills to handle the technological procedures. This leads to competence in health care that requires one to be motivated to respond appropriately. Rather than being competitive with colleagues, this represents an authentic excellence in all clinical roles. Noddings (1984) cautions nurses to use feelings to avoid being too abstract while being technically competent. Roach (1987) saw confidence as the center of all trusting relationships. Confident relationships dispel fear and powerlessness. She further defines conscience as nursing's moral compass. It is the awareness of the "right thing to do" in each situation as it confronts an individual. A professional knowledge base guides this awareness.

Further, Roach (1987) sees commitment as investment in a task where obligation is not a burden. Roach (1991) sees caring as manifested in compassion and competent care. It is a trusted relationship in those informed decision-making and problem-solving skills that result in moral commitment to choices and decisions made (p. 134). It is nursing's challenge to identify those attributes in the conversations and the lives of caring colleagues.

Roach (1991) states that commitment is an attribute of caring which fosters the maintenance of the client's dignity. Commitment leads to the second idea concerning caring, that is, caring as a moral imperative. Brody (1988) says that caring guides nurses in the identification of appropriate nursing actions. These nursing actions are completed in a clinically proficient and technically competent manner. Chablis (1996) defines competence as a technical expert even under pressure (p. 71). Roach (1991) sees competence as involving knowledge, judgement, skills, energy, and experience. These actions begin with a quality of presence that enables the nurse to be sensitive and attentive to the lived reality of the client. This presence prevents dominance over the patient and prevents treating the patient as an object.

Barry, the sixteen-year-old with the neurological impairment is never going to get any better than he is now. His pediatrician worries about him and what his illness is doing to his parents. The office staff comes to the hospital to see him. The caring circle around Barry is more than compassionate sentiment that raises a moral sense of obligation. Everyone involved in his care feels some sense of compassion for him. I wonder what it must be like for his mother. When I first talked to her, I had a sense of automatic connection. I see Barry as someone's son and as a young individual who should not have a grave prognosis. I know Cassie is experiencing some similar feelings. She writes about her feelings in her reflective self-evaluation. Her self-evaluation speaks of a general sense of concern for Barry. Cassie expresses this concern through her caring practices.

Caring as a Moral Imperative

Watson (1988) elaborates further on a caring action as "affirming the subjectivity of persons and leads to positive change for the welfare of others" (pp. 74-75). This action is reflected in the spiritual growth of the nurse when he or she says that there is meaning in his or her experience. Nursing's sense of what is morally ideal comes from caring within the nurse-patient relationship. The obligation to care for patients based on their needs is a constant in the profession. The forms of caring may vary due to constraints such as available time to spend with the patient or staffing patterns while caring remains a constant. Does caring have to be an effect to have this sense of what is morally ideal? How is it that the nurse knows how to click with a client? Is it not in this moment that a synchrony occurs in the nurse-patient relationship? It is then that a caring nurse attunes to the client's experience.

Noddings' (1984, 1992) theory has been criticized by feminist scholars who recognize the core element of her theory as the ethical self existing in relationships. They agree with Noddings that caring embraces the experiences of women, but are concerned about issues concerning both men and women. They are concerned that Noddings does not address the social, political, and economic contexts that continue to subordinate and oppress women and health care workers. Critics say Noddings' theory should address elements that continue to create oppressive conditions for women. Caring positions are low paying in health care since it is hard to attach a monetary value to caring work. The caring that the nurse wants to do is often delegated to others.

Watson (1988) and Noddings (1984) value caring relationships over outcomes and state what is important is the process of caring. Noddings (1984) states that we cannot separate means

and ends in education since the desired result is part of the process. The process stresses the notion of the person undergoing something and somehow being better as a result (p. 174). Card (1990) fears that if caring is the ethical ideal, then individuals will keep relationships that they should have dissolved.

Noddings (1984) sees caring as occurring "when one accepts the natural impulse to act for the present other" (p. 84). The person caring senses how the person being cared for really feels and begins to perceive what needs to be done for the cared person. Noddings says the memory of how one feels when caring, gives meaning to the interaction. Here one finds a congruence of perception and experience eliciting a response to expressed needs. This response requires active listening and a sense of connection. The perception allows one to be emotionally present to another individual. True caring nurtures another individual without diminishing the abilities of the caregiver or care receiver. There are engrossment and a motivational displacement by the one providing care (Noddings, 1984, p. 150).

The process of engrossment allows one to see the world through the eyes of another. Noddings (1984) describes "motivational displacement" as occurring when the one providing care incorporates the hopes, dreams, and plans of the one receiving care. Noddings views caring as relational which can also be unilateral. She notes that caring efforts can be measured primarily by how fully received by the other and whether the free pursuit of his projects is partly a result of the completion of my caring for him (p. 81). In a caring relationship, the ethical ideal is the vision of the best self (p. 84). The "best self" reaches out to other human beings. It is in this "reaching out" that human growth and meaning follow. The ethical self must be rooted as Noddings states "in receptivity, responsiveness, and relatedness" (p. 2). This determination of self in relation to others gives the professional the opportunity to make concerns concrete through practice. Noddings points out that rules and principles may harm the relationships that care is supposed to preserve and nurture.

Some feminist scholars have difficulty using Noddings' theory within the current context of women's existence. They believe that Noddings has not addressed how caring work is oppressive to women and how men express caring. Hoagland (1990) states that Noddings is directing care in only one direction with minimal acknowledgment to the caregiver. She sees this as causing women to become selfless and oppressive caregivers. She states that Noddings views caring as "disconnected from the political reality and social structure of the world" (pp. 109-113). Hoagland (1990) thinks that the lack of reciprocity in caring supports oppressive

institutions (p. 109). She fears that caring may not help women realize when they need to end a harmful relationship. I see this applied to nursing when nurses work to the point of exhaustion and forget their own needs. Fry (1988) asks nurses to give a realistic appraisal of each nursing situation since caring requires reciprocity. An awareness of this reciprocity helps nurses avoid being self-sacrificing and denying their personal needs. Educators must nurture and study the process by researchers.

Roach (1991) validates the importance of nurse educators and researchers to call forth the student's natural capacity to care and provide a caring learning environment. It is a caring stance that makes a nurse notice when an intervention is beneficial to a patient. They develop this stance through interpersonal relationships and involve an intent to care. Sherwood (1997) sees caring view as connecting the nurse to the patient and gives the nurse personal satisfaction. The personal connection promotes an awareness of a need with the intent to make a difference in the person's life. Specific interventions and interactions express caring based on knowledge. Roach (1991) sees this process as stressing connection and mutuality between caregiver and care receiver (p. 36). Morality in health care is best evaluated while in relationships that evolve from connection. This allows one to decide what is in the best interest of the patient. Keeping care as a gender sensitive ideal helps us in evaluating when care is important and what factors may inhibit care.

Caring as an Affect and an Interpersonal Relationship

May (1969) sees caring as beginning as a feeling. The person acts on these feelings and turns them into caring behaviors. Caring behavior requires thoughts and is the ability to be receptive to the needs of others. It is the ability to see the patient as a person with feelings and beliefs rather than a dysfunctional body. Morse and others (1991) see care as more than emotion but a feeling of compassion that motivates the nurse to provide care for a client (p. 123). Roach (1987) says it best when she says it is a total way being, of relating, of acting on one's thoughts toward another. Benner and Wrubel (1989) define caring as thoughts, feelings, and actions. It involves being "connected and concerned" with the client so that caring sets up the possibility of giving and receiving help. It enables the client to cope and deal with what is stressful and to find meaning in a situation. The emotional nature of caring is devalued and invisible. The technological competency required by health care institutions sometimes makes it difficult to foster caring relationships. Institutional incentives for nurses to care do not exist. The hospital

environment does not allow nurses to document the value of caring interventions or the importance of nurse-patient interventions.

It is within the nurse-patient interaction that caring is expressed and defined. In this interaction, the feelings (affect) and behaviors (interventions) are, ideally, expressions of caring. Knowledge and skill need to be the basis of caring interactions. Caring interactions are as specific as attentive listening, touch, competency with procedures, and advocacy. The caring behaviors of nurses help individualize these interventions. Noddings (1984) focuses on the caring behaviors exhibited in human interactions. These behaviors have moral intent and involve receptivity, relatedness, and being responsive. Mayer (1986) sees the major components of caring as the attributes of the nurse and client, the interpersonal process, and the specific behaviors that convey caring (p. 64). If this interpersonal interaction is initiated to meet a client's goals, then it becomes therapeutic. They intricately tie caring to the nurse's beliefs about individuals and how he or she perceives and responds to these individuals. Caring understands which actions lead to actions and outcomes. Brown (1986) says when the nurse recognizes the unique needs of the individual patient, then nursing actions become therapeutic caring interactions. Caring is directly linked to the work of nurses.

Many people care for Barry, and no one cares more than his parents. The care that he experiences is similar to the care other patients experience and feel. Care is operationalized through dialogue, role modeling, confirmation, and practice. To sustain care, we need to talk about care in nursing and practice it. Caring becomes therapeutic when you are authentic in your practices.

The Therapeutic Interaction of Caring in Professional Nursing

Morse et al. (1990, 1991) delineate these caring therapeutic actions as attentive listening, patient teaching, patient advocacy, touch, technical competence, "being there," assisting with pain, patient assessment and observation, providing information, and offering reassurance. These interventions are patient centered because the nurse recognizes individual qualities and needs in the patient. Brown (1986) says that the nurse modifies his or her care to fit the uniqueness of the patient (p. 58). These interactions are expressive and instrumental expressions of care. Excellent nursing care requires physical, technical, emotional, and intellectual components. Caring nursing interventions are holistic in nature. Caring is a mode of thinking that sees the patient in context and promotes actions that meet individuals needs. The nurse attempts to see what the illness means to the patient and how symptoms have influenced the

patient's life. This is what everyone is trying to do with Barry. One of my former students was working at an extended care facility in an acute care hospital. She said that family was difficult for the staff to handle. She reflected that it helped her to remember that her patients were spouses, parents, and grandparents. If her spouse, parent, or a grandparent was ill, then she wanted their nurses to be there mentally, emotionally, and physically be there for her family member.

Watson et al. (1979) proposed a model of professional caring that describes instrumental and expressive elements of care in nursing practice. The expressive element is the affective component while the instrumental element is the physical component of care. These components of care are intentional and learned through formal education. Her group identifies two types of expressive caring behaviors that help in establishing relationships that offer support, comfort, and surveillance. Caring expressions are action oriented and are characterized by trust and empathy. They are considered healing modalities and are transmitted with therapeutic intent. The registered nurse who walks her elderly patient frequently to the bathroom does not want her patient to lose bladder control in the patient's bed. She shows empathy because she knows that an accidental wetting of the bed will harm the patient's self esteem. Maintaining the patient's self esteem and restoring bladder control is the nurse's therapeutic intent. The authors define physical-helping behaviors and cognitive-based behaviors. Physical-helping or instrumental behaviors include meeting basic human needs and technical competence, whereas cognitive-based activities include teaching, counseling, problem solving, and patient advocacy. Caring is the process by which nurses start nursing interventions.

Koldjeski (1990) links the expressive and instrumental nursing behaviors through three holistic indicators. The first indicator is being--a presence with the patient that involves compassion and interpersonal involvement. The second indicator, transpersonal caring, is relating on a personal, interpersonal and transpersonal level, seeing beyond the spoken word, and focusing on the whole client. It is seeing the patient as a person and not in a disease state while doing nursing interventions.

The last indicator is doing what encompasses nursing decisions and actions. This requires going beyond the nursing process and gaining a humanistic perspective of the client's illness experience. Benner and Gordon (1996) see caring practice as more than behaviors or strategies, since it involves being in nursing situations. It includes socialization and is unseparated from knowing or doing (p. 50). This ability is learned through formal classroom

work and the actual practice of caring. Since doing cannot be separated from knowing or feeling, the nurse must learn to be technically competent. With technical competence, an increased confidence enhances the nurse's caring capability leading to a balance of expressive and instrumental caring behaviors.

I see learning to be with the teenage boy with the neurological impairment as important as learning how to handle his tube feedings. Being in an actual nursing situation is something that a textbook cannot describe. The "being with" is as therapeutic for the patient as doing the procedure. It prevents you from treating the patient as an object. The student becomes more confident in the nasogastric feedings and others skills. Then, a caring stance can be used to note changes and individualize care for the patient.

Watson's Core and Trim

Watson (1995) expanded on the concepts of expressive and instrumental caring behaviors. Watson defined the "Core of Nursing" as therapeutic interventions that promote healing. Healing means obtaining balance in the client's life. "The Trim" is equally important but exists relative to the caring nurse-patient interaction. "The Trim" refers to the health care environment, technical procedures, and tasks that surround the nurse. This stance maintains the "humanness" of the nurse and client. Halldorsdottir (1997) says they should not reduce a nurse to a technician who only applies rules and does procedures on clients with specific problems (p. 115). If the nurse is only a technician, the patient becomes distant and merely an object. The nursing context and the health care environment shape a caring stance. This means that the nurse reflects on each new situation and client. They cannot use a "cookbook" approach in each situation. It also means that the social and institutional framework impacts caring.

Card (1990) expresses concerns regarding the lack of reciprocity in caring relationships leading to the development of oppression. She states that we are in relationships of which we are not consciously aware. She believes that Noddings ignores this when Noddings states that care is relational. She calls on an ethic of care that applies to our relations with people with whom personal and potential encounters connect us (p. 105). I see this as an awareness of when a relationship may not be good for you. Connection and a sense of community are both very positive attributes in nursing education. I think it is possible to get so involved with another that you want to do everything for them. Therefore it becomes important to be aware of your individual needs if you are a caregiver. This awareness prevents one from sacrificing individual needs when giving care to another. Card thinks that Noddings does not adequately address the

ethic of justice. She thinks this may have something to do with the fact that Noddings distinguishes between a feminine approach to ethics that is attached and a masculine approach that is both detached and based on rules and obligations.

Card (1991)calls for ethics that involve both care and justice that enable a change in the values each individual affirms (p. 252). This approach to ethics recognizes what may be different or foreign to an individual, and it acknowledges a self that is related to and yet separate from others. Differences are appreciated and the individual can be begin to address the inequalities of sexism, racism, ageism, and homophobia. She states that it is only within a just society that people can begin to care for those who are different from them. The individual then can understand and appreciate the other person's point of view. This idea is especially relevant for nursing since care needs to be individualized to each patient's needs.

Collins (1990) describes an ethic of caring that celebrates each person's uniqueness. She compares the bright and different colors that make up a quilt when she elaborates on individual differences. These differences do not distract from the whole environment, but like the quilt, the colors add to the expressiveness of the environment. It is through dialogue that people can begin to understand the contradictions in human life and begin to deal with oppression (p. 215).

They must embrace and appreciate contradiction and difference to gain further understanding. People develop caring, attachment, and connection in relational contexts. Caring involves relationships, nurturing, subjectivity, and compassion that are valued qualities in health care and education. These traits are often associated with women and receive no monetary rewards.

It is of note that women do not have exclusive ownership of caring and nurturance. Caring becomes more androgynous in a reciprocal and liberating environment. A non-sexist and nonracial environment is supported by a gender sensitive ideal in nursing. It avoids defining individuals from a gender or reproductive perspective.

Nursing education must use inclusive language and be sensitive to the issue of gender equity. Most important, this environment requires that we remove people from the margin because their sexual orientation, race, gender, or class differs from us. At that point it becomes important to address health care access from social and cultural aspects. Social structures influence the private and professional lives of caregivers instead of biology. When issues influencing women and other minorities are introduced and discussed from various points of view, it allows us to see how cultural diversity affects an individual's health.

Lewis (1992) relates how the dominant discourse of school knowledge differs from the student's own lived experiences of subordination. Gender and culture issues must address the experiences of the nonwhite race, women, lesbians, and lower socioeconomic classes. It becomes important to find ways of articulating knowledge gained from this experience (pp. 172-173). The medical model in health care displays unequal or subordinate relationships. The physician seems to have more perceived power than the nurse. The nurse has power over the patient if the nurse is not aware that an unequal relationship may exist. When a patient needing an expensive medicine at discharge expresses that he cannot afford it, my power as the nurse is to be aware of the patient's unique concerns and to address them. Possibly, I can find a source of assistance in the community to help the patient, or I can collaborate with the physician so the patient can use a less expensive alternative. Otherwise, I can do nothing and let the patient throw the prescription in the garbage can. I think issues of sexism and ageism are subtle, and one must reflect on experience to address them. A nurse or health care worker must constantly be aware of whom that patient is. If you are not aware of the patient as a person, it becomes difficult to address individual issues. I think it is degrading for health care workers to use slang terminology to refer to parts of the male or female body. If a patient hears this slang, he or she may become reluctant to return to the provider for needed health care. Sometimes nursing and other health care workers will say that a patient is non-compliant to a medical regimen. However the medical regimen does not consider difference or the patient's experience. I see it as important for nurses to consider culture, gender, and age when planning a health regimen. As a result, it becomes easier for the patient to adhere to a plan of care.

Bowden (1997) relates how nurses participate in the parts of people's lives when they are vulnerable and meaningful life is sometimes at risk. An important element of caring in nursing becomes appreciation of differences. If future nurses are to gain this appreciation, they must learn in an environment that supports differences. The inclusion of these issues shows nursing's concerns for the uniqueness of each person. It must begin with an examination of one's values and belief system. When we care for patients, nurses must examine the contextual elements of the caring relationship rather than physical tasks related to caring. Caring is a way of thinking and that opens a possibility that comes with constraints.

Travelbee (1966) said,

> No human being can be repeatedly exposed to illness, suffering, and death without being changed because of these encounters. They change the nurse because in being

> confronted with the vulnerability of others, she comes face to face with the compelling force of her own vulnerability, in a way that they cannot disregard (p. 45).

I see the entering into of any significant relationship as making one vulnerable. This vulnerability brings one to evaluate previous ways of being, valuing, and understanding. It becomes as if caring must be learned experientially. This experiential learning creates a set of practices initiated because of a need or vulnerability in another. A nurse evaluates specific contexts in pertinent environments. This describes the personal aspects of caring. Health care environments create contradictory realities for nurses. Nurses must learn to balance personal realities with social realities when caring. A nurse may want to stay home with a sick child, but her institution does not have flexible time. She wants to care for her child while she is caring for her patients. Each individual is given the tools to deal with these issues within feminist scholarship and must decide how best to accomplish this balance.

An additional constraint on nursing is a predominately female caring profession functioning within the medical patriarchy. In addition, nursing relationships are developed around vulnerabilities, inequalities, and dependencies at many levels. Nursing care can be complex because its aim is to overcome the patient's dependency and prevent treating the patient as an object. Kurtz and Wang (1991) say caring behaviors should be included in any cost vs. benefit analysis in managed health care. Caring interventions, such as support, education, and therapeutic communication, all have significant impact on health care outcomes. It becomes important for nursing education to increase awareness of inequalities within the health care system. This awareness occurs within a non-hierarchical classroom that values different standpoints and experiences. This classroom is conscious of the effects of gender, class, race, sexual orientation, and ethnicity on pedagogy. Students must learn to value their personal sovereignty as well as the sovereignty of their profession. This occurs with conscious raising that examines all possible contexts of relationships and situations. One cannot understand the importance of caring without examining how the context of a particular situation influences it in time and place. This situation can be both personal or professional while engaged in caring work.

Hierarchal structures within institutions can be dismantled through conscious awareness of the inherent uniqueness and difference in each individual. It is this awareness that replaces domination with closeness. It is through this closeness that patients, students, and clients refuse to be passive recipients of service. Women may learn they do not have to be passive in the

workings of their lives. Most important, this awareness means the answer is not in women receiving the same education as men (Martin, 1986, p. 9). Women must consider generative love as necessary element for the survival of society. Generative love involves the cognitive processes that preserve nurturing capacities in individuals. It involves a balance of rational thought and relationships. Generative love sustains care which allows one to act in the best interest of another.

A gender-sensitive ideal of education recognizes care, concern, and connections are all important concerns for education. It removes the tension an individual experiences when acquiring traits considered not appropriate for one's sex. The educated ideal considers both reproductive and productive processes for both sexes. Martin (1994) considers gender when it makes a difference and ignores it when it does not make a difference (p. 83). A gender sensitive ideal guides curriculum decisions and learning activities that empower students. This knowledge is based on a heightened awareness of unintended learning outcomes of a curriculum that centers on cognitive learning states (p. 157). I see student nurses learning "how to be there" for patients when it is role modeled by faculty and staff nurses. An intended learning outcome of clinical courses is role socialization.

Barriers To Care

It is caring as an affect that places the concept of care in jeopardy in certain public institutional situations. Care is still largely invisible and undervalued within the health care system. Insurance issues, government regulations, and requisites fail to recognize the importance of a caring nursing stance. Health care is an industry where the expressive elements of care do not direct. Incentives to care are lacking in institutions that socialize nurses to remain detached and "objective." It becomes difficult for a nurse to be objective when patients need a heightened consciousness from the caregiver or nurse. This heightened consciousness does not mean the nurse should work to the point of exhaustion. It requires a realistic appraisal of what level of care can be accomplished for the particular patient in time. This approach will help nursing control its professional destiny.

Martin explores feminist concerns and examines the unequal distribution of women in the reproductive and productive professions. She labels the "female" or caring professions as teaching, social work, and nursing. In the lowlands, she states that "you need not refuse to sell your brain for the sake of money, for no money is ever offered you; as for fame and praise, they reside on the heights" (Martin, 1994, p. 111). She sees individuals laboring in professions their

culture devalues and then developing a sense of irrelevance. Martin expresses the concern that what happens next is the caring individual loses a sense of self. The sense of self is lost as the individual struggles to become what the culture views as a genuine professional. An additional concern is the caring professional may become self-sacrificing. Individuals "defy the odds" and develop new ways of thinking. Martin states that women should not have to bring qualities together that education and profession tear apart (Martin, 1994, p. 114). There should not be a discrepancy between a woman's education and the life she is leading. She warns that with "professionalization comes decivilization" if there continues to be a split between emotion and reason (Martin, 1994, p. 113).

Martin wants educators to rethink their thinking. This rethinking examines women's experience with children. She wants nurses to integrate examples of women who have incorporated caring and rational thought into the classroom. This action is not just to "showcase" women's achievements, but to offer alternative ways of thinking, perceiving, and acting (Martin, 1994, p. 115). She warns nurses that this is not enough and one must practice alternative modes of thinking.

Watson (1995) states that a caring stance heightens a nurse's perceptions and promotes early recognition of a client's problems. This stance enhances knowing the patient through informed awareness. Health care institutions do not tie care into patient outcomes or recognize it in reimbursement issues. Individual institutions want quality care while containing costs. Institutions are often short staffed. It is perplexing for the individual nurse who finds it difficult to overcome these barriers. A proxy often does the care the professional nurse wants to give, with support staff giving the care for the professional nurse. Supervision of care does not necessarily equal transpersonal caring.

Caring needs to occur spontaneously and without interruption. It becomes important to identify the unique contributions of nursing which impacts the quality of care for patients. Williams (1997) states nurses need to know what are caring behaviors and how these behaviors create a caring environment. Seeing faculty role model a caring relationship is valuable for student nurses. Knowlden (1998) states that the educational process needs to show how nursing actions reflect caring.

Martin (1986, 1994) relates that education has used the concepts of objectivity, rationality, and self dependence. Liberal education had emphasized these concepts and neglected care, concern, and connection. A liberal education teaches that care is important but

neglects the process of caring. This position values rationality and objectivity and neglects the caring elements. This neglect leads to culture degradation that affects both women and men. Martin believes men learn to devalue caring, nurturance, intuition, and relatedness. Men will then have an impaired ability to experience their wholeness or humanness. Women learn to degrade other women and themselves. This devaluation becomes a part of oneself. Nurses learn that everyone else in the system is more important than they are. Like other females, nurses come to believe everyone else's needs must be met before their own needs. An important element of nursing for me is an intuitive knowing that develops from caring practices. Nursing education must address how students develop this ability and how they can nurture this process Caring of self is essential in fostering intuitive knowing.

The development of this ability is accomplished through various teaching strategies that encourage dialogue and reflection while providing the opportunity to practice caring. I see caring as a process of action rather than a set of specific behaviors. The individual practitioner acts through a model of caring that evolves from personal assumptions and beliefs about caring. If the profession expects future nurses to be caring with patients, students must learn in a caring environment where they feel connection with educators and practitioners.

Conclusion

Caring was role modeled by my mother and my great-aunt Margaret. They were very attentive to me and my siblings. My valued caring concepts evolved from my experience with them. Life has shown me how caring is invisible and should not be self-sacrificing. The writing of these experiences validate for me the role of education and caring in women's lives and their inherent paradox. The choices and decisions I make center around these concepts. I see caring as giving one a sense of intuition with others. It is through education that this intuition comes to fruition. Caring has detrimental effects unless it is viewed as a gender sensitive ideal. The use of narrative lets me see change in my life and others and work on making my caring gender sensitive. I write early in this chapter of the care surrounding the sixteen-year-old boy with the neurological impairment. It is something I can examine and scrutinize. I see care as relational and as promoting thoughtful and moral choices. I believe an individual must constantly reflect on his or her care giving. One can care best for another when he or she cares for self. Care surrounded me early in my life with varied contradictions and challenges. The tools to handle the challenges of care come with experience and relationships with others. It is the teacher's challenge to share these "tools" with students. These "tools"

come from the intuition one derives from a caring stance. This process means following your conscience rather than an organizational directive.

Martin (1994) writes about the contradiction and challenge by using the metaphor of the bridge. She deals with the issues of settling for less and not caring for self. It is very easy to settle for less than you are capable or less than you deserve. My study of caring has increased my scrutiny of gender sensitive issues. It is dialogue about lived experiences that heightens my understanding and allows for shared meanings between teacher and student. However, the student may not see this at times. I recently talked to a student advisee who is a licensed practical nurse. Before I could address her concern, I was mentally considering the following factors. She is divorced and close to my age. She is feeling stress now because the nursing curriculum is conflicting with her job at the hospital. She needs to work to stay in school and keep her health insurance. These are all valid and gender related concerns. These factors should not inhibit her from fulfilling her career aspirations. I perceive it is important that I at least acknowledge her concerns, and I am glad she is verbalizing them. I am also thinking of the male nursing student who is a displaced worker. I sense he works twice as hard as some of my younger students. He always follows through on the faculty members' suggestions. I always try to commend him on this accomplishments. For instance,when he made the highest score on the Nursing Care of Children examination, I commended him on his accomplishment.

Dialogue is the cornerstone of clinical nursing courses. In a clinical journal, a former student notes how close the cooperation is among the individual members of her clinical group. This cooperation stems from dialogue and examines the various attributes of care within the professional environment. I see this process as allowing the student nurses to learn and practice caring. If nursing is to keep care as a core characteristic of the profession, then we must give students an educational environment that values connection to others.

Care means many things to different people in various professions. In the description of practices, individuals relate how care is embedded in their practices. An understanding of how care is embedded allows one to keep instrumental and expressive equally important in nursing. Through the narrative process, I describe how I use care to grow as a nurse educator and to continue to talk effectively with students. This dialogue promotes the critique of practical knowledge and how one is with others. This shows both the teacher and students how to make sense of what one does as a nurse. I know I need to speak of what I do to make sense of my

work. If an individual gains a sense of caring work, then it becomes easy to value it and make it more visible to others.

Chapter Three: A Model of Caring

Caring is an essential element of life and must be cultivated by each individual. Caring as an art form has been taken for granted. It is assumed nurses care because it is instinct and a part of the human condition. Like the artist who plans and works out the details of each painting, a professional nurse must study the theoretical basis of caring and work at caring practices. I see caring as an art and a discipline that is informed by the sciences within the nursing profession. Caring is more than instinct and needs to be reflected on and skillfully applied in one's practice arena. Bevis (1981) says that "something as important to life, as central to life's fulfillment as caring deserves thought, study, and practice" (p. 49).

As with any art form one must be committed to caring, so knowledge and skill development occurs. Noddings (1984) says that caring is relational and requires engrossment, an energy exchange and awareness of the other's hope, dreams and plans. There is more to caring than engrossment. The feminist and humanistic models of caring and their cultural attributes help the nursing profession examine the multiple realms of caring. This stance will allow me to explore what constitutes caring practices and what is required to be a caring professional within nursing and nursing education. Since caring practices are firmly fixed in society and culture, I will examine internal and external barriers to caring. Finally, I will propose a model of caring for nursing education that is relevant for current societal trends.

The Process of Caring

Mayeroff (1971) sees caring as a "process, a way of relating to someone that involves development in time through mutual trust and a deepening and qualitative transformation of the relationship" (p. 1). It is within this definition I first viewed caring as a work of art. Natural caring is the way one exists and attends to caring in the activities of daily living. This natural caring is similar to Ruddick's "attentive love." Ruddick (1989) says that maternal thinking is central to caring work. She says "this loving attention represents a kind of knowing that takes truthfulness as its aims but makes truth serve lovingly the person known" (p. 120). This attentive love allows caring to grow from relatedness and guides one in doing what is in the best interest of the student and or patient. Actions center on preserving and promoting the growth of the care recipient. Ruddick (1989) tells how "a mother learns to ask again and keeps listening even if she cannot make sense of what she hears or can barely tolerate the child she has

understood" (p. 121). I see this as a voluntary practice that involves reflective thinking. This reflective thinking allows the caregiver to see the reality from the care recipient's world.

I do not consider myself an artist in the usual sense of the word, but I have spent time working on relationships. In the process of forming these relationships, I have learned to cherish and value individuals. I have also been committed to following through with this process and believed in the recipient of my care. Being committed to care requires an affective response; it is a way of being rather than a method of doing. Watson (1988) says this "way of being" supports the dignity of each individual. The dignity of the individual is supported when the person is sincere, because the one caring expresses feeling as it is experienced. Noddings (1984) says that caring as engrossment leads to being with another and then responding by doing for him or her based on need. Watson (1988) supports this view when she says, "It is art when the nurse, having experienced or realized the feelings of another, is able to detect and sense these feelings and in turn is able to express them in such a way that the other person is able to experience them more fully and release the feelings he or she has been longing to express" (p. 67). Watson speaks to the importance of nurse patient interaction. The centrality of caring nurse patient interaction is based on caring student teacher relationship. For it is in this relationship that students are nurtured to finding meaning in the learning environment.

I sense that Noddings and Watson are asking for an examination of the moral aspect of caring behaviors. I see it as a call to be responsive and receptive while connecting with others. Nursing is a caring profession that centers around meeting the individual needs of the receiver of the care. Meeting these needs requires the nurse uses his or her value system, while thinking through what approach best meets the patient's needs. It is not a call to be self-sacrificing when meeting another's needs. Noddings (1990) denies that her theory calls for self-sacrificing while feminist thinkers urge more emphasis on caring as valuable work. Yet, Noddings (1988) says that the caring perspective leads to an engrossment which promotes a sense of obligation that stimulates natural caring (p. 219). In a later work, Noddings (1992) states that engrossment does not tell the caregiver what to do but merely describes one's consciousness when caring (p. 16). It is engrossment that guides the nurse to do what is in the patient's best interest and should not hinder the well-being of the caregiver.

Addressing Power Issues in Nursing Education

In the light of the foregoing comments, the following question needs to be asked: How does a caring stance celebrate the power of human contact without it turning into a laborious task or oppressive task? I propose the answer to this question is vital to a model of caring in nursing education. I believe nursing education must create a caring environment that promotes the growth of students. This environment allows them to navigate the contextual elements that affect their patients. It must also stress caring for one self while caring for others. Nursing students are experiencing increased stress and are having a decreasing support base. The nursing educator needs to instill pride in the profession while showing students they are valued. To paraphrase Noddings (1992), a caring learning relationship in nursing is the nurse educator as the "carer" who helps students develop their capacity to care (p. 18). The capacity to care involves being attentive and being aware of others' needs or vulnerability. I see this as reflecting on the circumstance or the moment and placing value on the individual's point of view. It is through dialogue that I come to understand my students and my patients. Understanding does not equate with agreement, but it leads to heightened awareness of the other's world view. It is through this awareness that one can choose a certain stance which involves judgement and to some degree power.

I believe caring in nursing requires that power issues be addressed from the feminist perspective. Power and human needs change depending on context and circumstances. Power to make change occurs in caring relationships. A person with legitimate power shares personal meaning and tries to understand the emotional components of a situation. This sharing of meanings enables the other in a relationship. This understanding allows the educator to assist students in exercising their own inherent power from being a part of a learning community which enables them to accomplish goals. Students derive power from sharing values and beliefs within the student-teacher relationship ,which is central to the learning process. A nurturing environment is open, honest, and genuine with goal setting and mutual decision-making. This caring environment often remains hidden and unidentified. Paterson and Crawford (1994) state that nurse educators exhibit caring when they defend a student to a staff nurse or when they spend time with a student who is experiencing difficulty. These examples are caring practices that often are not discussed with others and therefore are invisible. Role modeling is a primary method for students to learn caring in the clinical area. Cohen (1993) views caring nursing practices as knowledge constructed from lived experiences in education and practices (p. 624).

Belenky et al. (1986) studies how women understand their world and learn. This research describes five categories of knowledge deployment documented from extensive interviews of women with consideration of developmental changes. Constructed knowledge involves a positive sense of self with the knower an intimate part of what is known. Nurses must listen to their own voices to balance issues of power. This involves moving away from "either/or" distinctions and being aware of one's internal contradiction.

There exists the possibility to exert power over another in the nurse and patient relationship. The process of receiving care can accentuate feelings of dependency in patients as well as students. It is important for student nurses to feel empowered so as to facilitate positive change in their patients. I believe this comes from egalitarian relationships within the professions. It begins during the educational process and continues with the encouragement of mentor relationships. It starts when a individual recognizes the importance of not doing violence toward self and others. Empowered students work at problem solving and strive to improve their communication skills. Educational empowerment encourages dialogue that leads students to understanding their patients' dependency needs. This deliberation prevents an individual from giving power away because of failure to care. Failure to care means one is passive and accepts the status quo.

Faculty need to care about the power they have with and over students. Personal development is fostered by believing in the student and showing them that power comes from working together. In working together, faculty and students see what exists and then envision alternative ways of responding in a situation. This requires reflecting on real situations and generating ideas for solving the problems. Knowledge is gained through active reflection that permits one to know how and why something occurs. I see this as active learning and essential in nursing education since nursing students must apply theory in a variety of clinical settings.

Reflecting on the Idea and Ideals of Nursing: A Vignette

Nursing students must link and reflect on ideas, ideals, and thoughts and then develop personal meaning while learning. In one clinical situation recently, I decided my nursing students needed to do some brainstorming and come up with their own solution. They needed to resolve this because they need to be active participants in their own destiny. If they are active participants, then they will see a need to be supportive of each other. Allen and Farnsworth (1993) state "reflexivity is a critical process of increasing self-awareness and sensitivity to the experiences of others" (p. 351). This reflexivity considers multiple contexts and considers the

lives of teachers and students when considering pedagogical practices (p. 352). The following vignette exemplifies both the use of reflexivity and problem-posing in the clinical area and there are multiple paths to learning. Hokanson Hawks (1992) states that problem posing allows the educator to situate learning within the student's environment and this process is congruent with empowerment (p. 615). Problem posing challenges the existing environment and requires student nurses to actively examine how their beliefs and views impact their didactic and clinical learning. Nursing knowledge involves more than the transmission of rules and facts but involves multiple world views. Benner (1994) says that caring is integral to this knowledge and involves skill and being in relation to others (p. 45). It becomes crucial that students examine the impact of relating to each other in a caring learning paradigm.

My student nurses, Darcy and Penny, need to gain knowledge through reflecting on what should be done regarding the potential health cleanliness and professionalism issues of selected colors of nail polish that have arisen in our clinical group. Our group was in the midst of the team leading experience. Each week a student team leader grades the team members on their nursing performance. Penny is upset because Amy deducted points on professional responsibility because she had nail polish on last week. Penny comes to me because this week's team leader, Darcy, is wearing the same shade of nail polish that Penny wore last week. By the end of the clinical day, I am sick of the nail polish debate. I think it would be easier to lower everyone's grade who has worn nail polish in the hospital setting. I see that the involved students can chart the best course of action as I ponder why they are making this an issue. These students take good care of their patients and are otherwise very responsible. A correlation between the color of the nail polish and the quality of their nursing care does not exist. This issue should not hamper the group process. Is the issue of wearing nail polish an old nursing ritual? I ask them to reflect on the nail polish issue and what is happening to their group. They need to be supportive of each other, and the strife is hurting each of them. I tell them to decide how our clinical group should handle the nail polish issue. I ask them to analyze why the color of nail polish created conflict and decide what constitutes a professional appearance. Darcy says in a whining voice, that I am the teacher and have the final say. I respond that you are graduating in May and can come up with a solution. You should tell me what constitutes professional nursing attire and what you can begin to do now to support each other. I am not going to just lower everyone's grade who wore nail polish to the clinical area. I am posing this as a problem and expect those involved to find the solution. In your professional career, you will

need to be proactive about issues facing registered nurses. There are multiple ways of completing a task and understanding a situation. Both I and the clinical group can learn from what you conclude.

They debate the issue and decide wearing nail polish does not impact their ability to care for patients. It is decided that chipped nail polish looks sloppy in the clinical area. They feel power became an issue when Amy gave Penny a lower score because of the nail polish. They decide it is too close to graduation to be arguing over trivia. However, I am not sure if they see the need to be active participants in this process and why I believe it to be necessary. The issue of personal power to institute change is not stressed or nurtured in most nursing curriculums.

Student nurses need to be proactive in professional decisions and motivated to care for patients. This starts with faculty who avoid "power games" and who will not tolerate it with students. First, faculty must support each other when the need arises and celebrate each other's accomplishments. Unfortunately this does not always happen, but it should be the ideal model for students. I am not sure I have the answer to this except that it can begin one person at a time. I try to commend my colleagues when they accomplish something and walk away from the gossip and innuendoes. It is important to be supportive of each other for the profession and the students. If it is role modeled for students, then role inculcation may occur during the educational process.

Faculty care about students when they recognize the times students have done their very best under circumstances by acknowledging this. This process involves avoiding being harsh or judgmental when the student is less than perfect. Sometimes the nurse educator needs to be the "co-learner" rather than the expert. It involves being more interactive and less rigid in the cognitive process. Faculty need to learn to listen from the student's perspective and not their own agenda. This is hard because many faculty have been educated in an oppressive paradigm.

The Feminist Perspective on the Process of Caring

Feminist perspectives are important because nursing is affected by a changing health care system and a history of oppressive roots. Staffing patterns vary within institutions and managed care impacts how care is given and by whom. In today's health care system, caring is still invisible and undervalued and nurse caring is often done by proxy. Most important, future nurses need to care about the profession and what it has to offer the health care system. This process starts by caring for self first. If nursing is to be valued professionally and publicly, then emphasis needs to be placed on caring practices and their impact on health. It is now time for

nurses to be more autonomous in deciding what is the “market value” of their caring. Nursing students need to be consciously aware of the inherent uniqueness and differences in each individual. This awareness allows us to begin making connections with others in the profession. This heightened consciousness allows students to come to care about things they may not have always seen. This process allows one to identify domination in the environment and to begin to reconstruct it. This requires thoughtful and caring inquiry about nursing practices and how these processes impact lives.

Caring involves autonomous thinking and acting on what one sees as the best course of action in a situation. A caring stance centers on what it means to be human and guides technical competence. A caring nurse needs to be technically competent. A technically competent nurse allows caring to guide technical procedures. Caring promotes the good use of science in health care. For example, one of my colleagues is an adult nurse practitioner at a free health clinic where she has been treating a middle-aged women with fibromylagia. She sensed the antidepressant the women was on was not working, and she taught this woman guided imagery, stretching, and yoga. This woman comes back to the clinic every two weeks to practice what she has learned under her supervision. When I covered for my colleague at the clinic when a family emergency arose, she told me that I can cancel this woman, but she thinks the patient needs to have the contact since she is feeling better and is following through with imagery and exercise. I know I can do the imagery and stretching, but I am at a loss with the yoga. I review the chart prior to meeting the patient and then do a brief examination. I am amazed with her progress with the guided imagery, and she is anxious to start stretching exercises. I show her all the stretching exercises I think will help her trigger points, and in return she demonstrates what she knows. I think nothing of it until my colleague stops by my office and tells me how my stretching exercises helped this woman and what progress she is making with the yoga. The patient wanted me to know the stretching helped her pain at the trigger points. I am gratified she is telling me this. I think it is really important to listen to patients and to try different modalities. Nursing is about healing the spirit as well as the body. Just treating the body does not heal the patient’s spirit. I think this patient’s spirit was healed because she was maintaining her health.

I want my students to know when our profession can guide someone to a sense of well-being and when it is appropriate to use science or technology. Nurses must be attuned to the patient’s environment to adapt or guide the technical competence to meet the patient‘s needs. To do what is in the best interest of the patient, a nurse must know the patient as a person and have a

sense of the environment. Most important, the nurse's sense of concern guides knowing the patient and then doing what is in the best interest of the patient. It is the nurse's spirit that allows connection and growth. Simone Roach (1987) views caring as the source of conscience and conscience as the call to care. My conscience called me to question a situation recently and not accept the status quo. I needed to examine the internal and external barriers to caring within the present health care environment.

A Vignette: Illustrating My Model of Caring

It was my first day back with the second year nursing students, and we are ready to report to the floor. Jane says she does not understand why we need to make those home health visits and do discharge planning. She feels it is such a waste of time for us, and we need to be taking care of patients since we are close to graduation. I shake the table with my hand, just enough to spill my coffee. I say, "Jane, you need to care for patients and know what it is like for them at home. Then you will see what obstacles each patient face at home, and you can care or plan for them better in the acute care setting." Jane slightly smirks and Lea giggles as we leave the conference room for the floor. Jane is caring for her two patients in room 14 when I hear from the charge nurse that the patient Jane is assigned to in room 15 is going home. I rush to Jane to question whether she knows that her patient is going home. She is very surprised and says, "No, but I will check with the charge nurse." I am reviewing with the other students when Jane says, "Ms. Dragich, Mr. Balling is going home now and the volunteer has him in the wheelchair. The charge nurse gave him his discharge instructions, and I did not have a chance to even talk to him." Jane speaks to Mr. Balling now, and I suggest she may be able to make a home visit. Jane discovers Mr. Balling is walking home and no one is accompanying him. Home is a downtown motel that has been converted into efficiency apartments. The charge nurse wrote a message on the progress notes that Mr. Balling crumbled his prescription slip and put it in the garbage can because he cannot afford it. Jane informs me the medication is Celebrax. I tell Jane that he can take the prescription to the free clinic and get it filled. She says that Mr. Balling does not know about the free clinic. The charge nurse says that he is ready to go home now, and a volunteer is ready to take him downstairs. I tell Jane that she needs to talk to him right now about the free clinic and set up a home visit.

I speak with the charge nurse, who says that he is ready to go, and confirms she gave him discharge instructions. She is a nice person, very good to students and patients, but something just does not feel right. When I ask her about the Celebrax, she says that she documented it in

the chart that he cannot afford to buy it. I neglect to question why she did not have one of the case managers see if they could get the prescription for him. I am questioning this patient's imminent discharge, but I am not really challenging it. I am not an employee of this institution, and I am thinking about all the things that I have yet to do. Casey and Tam need to do a dressing change and they picked up the wrong packing. I am hoping they are looking for the right material now. I contemplate what Fisher and Tronto (1990) say about the components of caring. Tara, the charge nurse appears to be caring, but is she really taking care of Mr. Balling by just making a note in the chart. I ponder this because there seems to be an inherent contradiction in what she says and what she is doing. It is as if she has adopted the norms of the dominated culture, and I seem to be doing the same thing. Then I tell myself this is not my job, but maybe it is my moral responsibility. There are two registered case managers on the floor, and they are at their computers and not managing Mr. Balling's care. I want Jane and her classmates to see caring is more than benevolence and that it includes recognizing a person's need or vulnerability. I try not to be critical, but the routines in the current health bureaucracy concern me. I am certain most nurses want what is in the best interest of the patient. I cannot presume I know what is the best interest of the patient. Is it that the institution has defined what nurses are allowed to care about so as to transform into a beneficial activity? Jane comes toward me and starts talking about Mr. Balling while I contemplate these issues.

I made an appointment with him so I could do a home visit for the community course. Jane goes back to caring for her patients in room 14. I am wondering about Mr. Balling and hoping Jane sees the value of these home visits now. This visit is valuable to the patient since the student plans an individualized teaching plan. Jane may develop skills in perceiving and attending to things that impact her patients' lives. I wonder if she and the other students are seeing caring as "a practice involving certain ability factors, such as time, material resources, knowledge, and skill" (Fisher and Tronto, 1990, 41). I am having trouble seeing why Tara allows Mr. Balling to crumble the prescription and place it in the garbage. This situation involves Mr. Balling's lack of resources and someone's lack of the ability to see or the skill to attend to his need. It may simply mean that care as defined by an individual nurse differs from how the nurse's employer defines care. I wonder how this impacts one's autonomy and ability to care. I certainly did not go overboard and speak up for Jane's patient. My role is to encourage Jane to question why alternative medications or resources are not explored for Mr. Balling.

When we are in the conference room later, I ask Jane to talk about her experience. She relates that she cannot believe he walked home by himself and he lives in a motel. I say that caring for Mr. Balling involves more than the narrow sphere of the hospital. Making home visits allows you to see your patients holistically, and this facilitates care and thinking beyond the acute process. When Jane tells everyone he is living in the downtown motel, her classmates cannot believe it either nor that he walked home alone. Jane says Ms. Dragich made her point because she sees why we need to make these home visits. As we leave the hospital for the day, I think I have just connected with Jane because she shared my concern about Mr. Balling.

I start my second week with the fourth semester students on the medical surgical floor where Tara is the charge nurse. Tara attentively listens to all the concerns the students take to her and offers helpful suggestions to them. I see where she is very patient when others would be "short" with them. Sandy comes to me and says that Tara is one of the nicest charge nurses to the students nurses and what a good role model she is. I brought it her attention about one of the patients needing to use inhalers after the heated nebulizer treatments, and we went together to talk to the respiratory therapist. She makes me feel what I say matters to her. I agree with Sandy, but I am wondering about last week with Mr. Balling. I see this as institutional socialization with Tara, and she may not be aware of it. I am wondering about my own socialization and thinking.

There seems to be an inherent paradox in her behavior or she just does not know about these outside resources. There is a shift in thinking, but it is Jane and her fellow students that have benefitted from it. Most important, I sense I have been too quick to judge and mentally criticize Tara. I see this as a fault because I believe nurses are sometimes their own worst enemies. I want to improve and work on relationships between practice and education. My students learn from Tara and maybe Tara may learn something from them. I am in deep thought as I see Jane come toward me.

Jane says that she and the community instructor, Mrs. Thomas, are making a home visit to see Mr. Balling at his efficiency apartment on Friday. Jane spoke with Mr. Balling on the phone and talked to him about the free clinic in the Union Mission where he can obtain his medications free of charge. She says he seems very interested in going there if he can get a ride to Bluefield. Even though Jane comes from a very rural area of West Virginia, she giggles and says she cannot believe that he lives in a motel since his wife died. It is incredible he lives in a motel because she thought everyone could at least afford a house.

After talking to Jane, I ask the case managers, Patty and Kathy, about what do you do if you have a patient who cannot afford medications. Patty is not sure and says since she just started she would ask Kathy. Kathy knows about Health Right, but she cannot explain why "the system" did not work for Mr. Balling. I am sensing he did not have technical procedures or physically involved care, and he was marginal to their sphere of things. His need was invisible until Jane came into his immediate realm. I guided Jane toward the free clinic because I work there, and I know that population I serve. I am not the community instructor, but I feel an obligation to Mr. Balling, the community instructor, and her classmates. This sense of responsibility is intricately tied to my model of teaching. I see it as a process of inquiry that involves values, beliefs, knowledge, and skills. This vignette demonstrates that through thoughtful inquiry students, teacher, and charge nurse are all co-learners. In the process of learning, it is important to understand there are multiple ways of understanding or arriving at the truth. This stance permits understanding of difference and one's actions may marginalize another. It is the why and the how of doing something which leads to questioning outcomes. Questioning permits problem posing and the seeking of alternative solutions. Problem posing demonstrates the importance of situating learning within the environment that students know. This leads to the students' active involvement in knowledge acquisition and fosters the development of values. Students begin to understand the meaning found in a health or developmental challenge. The process of caring shapes understanding of the meaning behind a situation. Caring practices make one more receptive to the unique needs of the individual.

Teaching Caring Practices

I view caring as a cultural and social practice that is embedded in my way of life. A teacher needs to reflect on and foster students' inquiry on what is going on around them. Every student comes with an individual history and differences that have innate meaning. It is important to get to know each student individually and to decrease his or her anxiety. This way a student is less an object or a number to me. Caring requires unity of thought and action. I believe as a nurse educator I need to help students recognize their patients are vulnerable. Patients are vulnerable because their choices about being cared for are limited. I also need to let students know I care for them. In this sense, I set the climate or make the environment for caring. It is through interaction that the climate is set that fosters receptivity and relatedness. I am stressing interaction because it involves being attuned to what the student is saying or doing. I think emphasis should be placed on the endeavor and not the outcome. You cannot reach

everyone with every encounter. In an encounter a teacher can begin to connect with a student, and it becomes easier to see things from their perspective. Seeing things from their perspective helps in assisting them to see beyond the dominant culture and allows them to see the patient's perspective. This stance models being an active participant in what is occurring around you. Future nurses need to learn to navigate health care institutions which are bureaucratic. These institutions tend to be standardized and see a good employee as one who is passive. A nurse needs to be an actively involved employee for self well-being and do what is in the best interest of the patient. Caring is still so invisible in these institutions because it is something that is not measurable and cannot be quantified for reimbursement.

Teaching caring practices requires we celebrate and talk about the times we see nurses and students caring. Talking about caring permits us to validate encounters and relationships that do make a difference in the outcome for patients. The outcome may not be what is anticipated because context and circumstances differ. Because contexts and circumstances differ or are unique to individuals, caring is needed to guide technical competence. One needs to understand what meaning contexts have for patients. This approach allows us to examine what is caring and not caring, and what leads to controlling or oppressing behaviors. It is essential to consider current and past contexts because people do not fit into exact molds and learning needs to be situated where the student is now with respect for his or her way of being. For the student to receive optimal benefit, this situated learning occurs where patients live their lives. Therefore professional nursing is more than doing procedures and taking care of diseases and relates more to promoting health and well-being. It includes a world view that recognizes community and each individual is connected to someone or something. Gordon (1996) says that caring exists in relationship and flourishes or sours depending on social context (p. 262). The social context guides one in "how to be with people" (Benner and Gordon, 1996). If you know how to be with a person, then the connection will guide the use of technology and recognize when a caring therapeutic relation is in the best interest of the patient. This sense of community values the student's previous experience. This connected teaching permits the expression of alternative views and nurtures the student's learning.

Hedin and Donovan (1989) state that "education with a feminist intent is integrative and inclusive rather than exclusive of people and ideas" (p. 9). This means to understand social context, one needs to be conscious of gender, race, class, and ethnicity. This consciousness follows what Noddings (1996) says is the receptive modes of caring where energy flows.

An important element of connected teaching in nursing education is the discussion of care by proxy and how practicing nurses should deal with it. Care by proxy is the trend in health care institutions to hire caregivers to assist licensed nurses in the delivery of care to patients. It becomes important for the nurse still to make contact and connect with the patients through the routines of life and what may appear mundane. It is easy to forget this type of care because it is still invisible and not valued by individuals and institutions. There are times when a patient will say something during a bath that he or she will not mention during an interview. I propose if we start with students valuing the mundane tasks, then nursing professionals will document the time doing the inconsequential task may make a difference in a patient's outcome. This documentation of outcomes makes visible and reimbursable professional nursing care. This is a major step and may be a very nebulous undertaking, but needs to be done because it is not business as usual in health care facilities. It requires nurse educators be attentive to current health care trends and realize it is important to be there for students. By being there, I mean to show up mentally and physically for the students, and this requires attentively listening and working on relationships. I regard my students as intelligent and hard working individuals. I challenge and encourage their commitment to the profession.

A teacher must recognize the value he or she brings to each encounter and help the student develop self-confidence. It involves attentive listening and not just hearing from the instructor's perspective. I always tell my students not to tell me what they think I want to hear but what they see, hear, and feel. It is very important to be honest and allow them to see they are worthy of being here. Unfortunately, there are students who doubt their self-worth. I make the attempt to connect with each student and encourage his or her optimal development by first telling them they are worthy individuals. Sometimes it is not easy to do this because people are different. People do not act as you expect them to do. I have learned not to be attached to the outcome because outcomes can turn out to not be as one had hoped. I still try to show concern for a student without accepting second-rate performance. This comes with time and lots of mistakes with individuals because it is easy to get attached to the outcome. It involves rethinking what is important about what is taught and realizing some things are beyond our control. Hokanson Hawks (1992) views connected teaching as acknowledgment and validation of prior student learning and experience, and this helps student recognize what they already know (p. 615). This realization is a starting point in making lasting change in one's personal and professional environment. Hedin and Donovan (1989) stress that feminist education involves

relatedness and connectedness. The connectedness allows learners to see power comes from the process of working together (p. 9).

The crux of the caring process involves caring for self as well as others. Brody (1988) states that a nursing ethic of care rejects selflessness and nurses should not work to the point of exhaustion (p. 94). Brody (1988) says "nurses must accept an honest appraisal of what level of care nursing is capable of providing that nurses will control practice and be truly capable of sustaining the caring aspect of their profession" (p. 94). Pinch (1996) supports Brody's concerns with the following statement: "A continual focus on meeting the needs of others--without renewal, re-energizing, and respite wears out the person caring" (p. 86).

I see this as an important construct in a caring model of nursing. Nursing students must be guided to see caring as an androgynous ideal. An ideal that centers around balance within one's personal and professional life. The balance requires the individual care for self as well as others. I think caring for self allows one to be caring in the moment, when one faces the desire to be uncaring.

Conclusion

Care is a way of being with others that evolves from human experience. Such experience connects us to each other while offering reciprocal presence. I see presence as enabling a human connection that values human dignity. This sense of presence allows the caregiver to tend lovingly to another person. This attention allows one to begin to know another and permits you to see what that individual needs at a particular time and place. I believe this requires a person to be authentic with others. An authentic person or nurse does not abuse power and is true to self and the profession. I see this as leading to increasing self-awareness and self-esteem. A self aware and authentic nurse sees the good in others and the nursing profession. This empowering stance encourages students to solve problems rather than the educator in the authoritative role telling the students what to do. This is exactly my standpoint with Darcy and Penny. I think constantly telling people what to do can be oppressive and leads to passivity in those individuals. I want students to be active participants in their education and in the nursing profession. Since this chapter illustrates my model of caring in nursing and nursing education, I would like to illustrate this point with a concluding vignette.

Vignette

It is my first clinical day with the fourth semester students since returning from a National League of Nursing meeting in Chicago. I always enjoy being with the graduating

students in their last clinical course. Jason is one of my students; he reminds me of my two sons. I am Jason's advisor, and I had him fall semester for the mental health clinical nursing course. The instructor who covered for me while I was at the conference sent an email stating how she is concerned about Jason. Jason seems "down" because he did not pass a test in another course. In her opinion, Jason has met the objectives for the clinical day. I think she would not have sent me the message if she had not sensed something different about him.

I usually introduce myself to all of my students' patients. One of Jason's patients is in a private room away from the nursing desk. The patient is in isolation because of a decrease in his white blood cell count. The gentleman is very vulnerable with his current health status. The isolation is increasing his vulnerability since the caregivers need to put on a mask and gloves when they enter. Jason is vulnerable because he has concerns over the test he did not pass. I am concerned when I arrive at this patient's room because Jason is not there. I see the patient's intravenous bag is almost empty. I could change it, but this would be too easy of a solution. I excuse myself and go looking for Jason in one of his other patients' rooms. However, I find him in the computer room looking up some information. I softly express my concern that he has not been attuned to the basic needs of his patient. He says, "I did not notice the intravenous bag when I was in the room. I am sorry." I could have scolded him at this point or reminded him that he would soon be graduating. Jason knows these facts and it might adversely affect his fragile self-esteem. I simply say you need to be there for your patient, Jason. Jason's story does not end here. I keep seeing him at the nursing desk and talking to his friend. I pose questions to him, and he seems to answer them. After I dismiss the students, his patient in isolation puts on his call light. This patient has increased swelling around the site of his intravenous catheter. He has developed an infiltration, and I would have hoped Jason would have caught it earlier. I am thinking I should have made him stay with his patient more. The quick way would have been to exert my power over him. This approach would not have addressed what is in the best interest of Jason. As I ponder this issue with him, I realize Jason lacks presence with his patient

I decide to present this issue to Jason and will listen to what he has to say about my concern regarding his lack of presence. I will offer him some suggestions on how to increase his sense of presence. This sense of presence leads to intuitive knowing and is as important as technical proficiency. This intuitive knowing and presence is hard for beginning nurses and students to grasp; however, I have seen some nursing students grasp this concept easily while caring for patients.

One of my colleagues who accompanied me to Chicago mentioned this lack of presence indirectly. Sally was stating how students want to do multiple complex procedures. By doing so, they think they are very involved in nursing. However, sometimes they forget to hold a patient's hand, to listen, and to offer a comforting touch. This requires showing up and being there for each patient. Jason has this capacity because I have seen him being authentically present on other occasions. I think he just lost sight of his caring stance. I need to be authentic and caring for Jason as I address this issue with him. My task in the next several weeks is to engage Jason in thoughtful inquiry so he will care better for himself and his patients. Then he may have increased self-awareness regarding his strengths and weaknesses. Another outcome for him is that he will be there for his patients. This vignette summarizes how I practice caring within nursing education.

Chapter Four: The Practice of Caring Within a Nursing Curriculum

Introduction

A model of caring is carried out in the nursing curriculum and involves the lived experiences and interactions of teachers and students. A learning outcome of a caring-based model is student-teacher interaction that empowers students and patients. Student nurses develop caring naturally and discover the meaning and use of care while they are learning and doing. Students find meaning by considering what an individual patient needs in a specific moment in time. The outcome of this process is a balance of the expressive and instrumental elements of care within a health care environment. Students exhibit attentive love for a patient, and I see this as a hallmark of a caring professional nurse. I want to share a scenario where my nursing students seem to know what a specific patient needs at that moment.

It is spring and my fourth semester students are anxiously awaiting graduation. They are assigned to a medical surgical unit for their last practicum course. Barbara is a quiet thirty-eight-year-old single female with multiple sclerosis who has a decubitus dressing and is on an air mattress. She requires much physical care, but something else is bothering her. The staff says she is an ideal patient for nursing students because she needs constant and individualized attention. Barbara is on a very busy nursing unit, and the staff cannot seem to make her happy. They easily accomplish the instrumental or technical elements of her care; however, she is a difficult patient emotionally and physically. Barbara says she is trapped inside her body and seems depressed. She does not have a strong social support system and feels powerless over her care. The patient needs to eat to heal the decubitus but does not want to eat. Barbara believes she is a burden to all caregivers. She needs nutrition and someone needs to assist with her feeding, but very slowly. She wants someone to listen to her and doing things her way requires extra time and involvement. The nursing staff says Barbara does not realize they are caring for other patients. She needs a lot of emotional care and presence from the nursing staff. This sense of presence is hard to document in tangible terms, and it can cause the caregiver stress.

Susie, a fourth semester student is assigned to Barbara and two other patients. When I check on Barbara, she is mumbling something about not having a care partner. I see Tonya has come to help Susie care for Barbara. Barbara is talking to them about how the multiple sclerosis has affected her life. Later that afternoon, Susie, Tonya, and I talk about her and her nursing

needs. This patient is both a textbook case and not a textbook case. Susie and Tonya express that dealing with her anger is hard, but they want her to express it. Susie says that the anger makes her an active rather than passive recipient of care. Tonya says that Barbara needs someone to listen to her because Barbara feels the doctors walk away from her. It is the walking away that bothers Barbara because she cannot walk away.

Susie and Tonya say it is through the interaction with staff, faculty, and patients that they have refined the process of giving care to a chronically ill patient. I see this occurring through guided instruction in clinical nursing courses. This gives students the opportunity to use caring concepts while providing technical care. The students see compassion as important as technical competence. I see this as giving a heightened consciousness of what morally is right because of a sense of relatedness. The result is the empowerment of the nurse and the patient. Susie and Tonya handled this patient well and were attuned to her needs. They did not walk away from a difficult task. Their abilities to meet her needs were empowering to them as soon-to-be graduate nurses. I want to reflect on what factors helped care in this nursing situation.

Leininger (1986) defines care facilitation as factors that enhance or allow nurses to discover the full meanings and use of care within their thinking and doing (p. 2). I propose that care in nursing education is enhanced through dialogue and role modeling. Dialogue with instructors, clinical nurses, and fellow classmates allow individuals to enhance the capacity for attentive love. This leads to an intuitive sense that examines human concerns while learning technical competence. This intuition is enhanced through role modeling which also leads to an awareness of the factors that inhibit care. Caring is difficult to quantify and is not perceived as cost efficient. For care to be more visible, it needs to be discussed and practiced in education and the professional environment.

Bevis (1989) sees curriculum as those transactions and interactions that take place between students and teachers with learning as the intent (p. 72). These interactions are opportunities for faculty to role model caring and technical competence even when their actions may fall short of the students' expectations of the faculty. Leininger (1986) calls on faculty to be competent care clinicians and role models to nursing students. She also says that nurses who value and practice care are excellent role models for caring (p. 4). Students reflect on their experience with professional nurses and see how compassion, commitment, confidence, competence, and connection are all equally important when caring for patients. Noddings (1988) supports this when she ties the relational ethic of care to experience (p. 218). The task is to

examine how the culture of nursing education facilitates care as the crux of the curriculum. Caring interventions are essential nursing knowledge and make nursing contributions more visible.

Care in nursing education is enhanced through dialogue, role modeling, and reflection. The student learns to examine human concerns while learning technical competence. This stance is obtained when the individual is aware of factors that inhibit care.

Leininger (1986) examines those factors that limit or impede the use of care in nursing (p. 2). Resistance to care remains in nursing education because curriculum is still content driven. A content driven curriculum places minimal emphasis on the process and impact of care. Reflection on diversity allows students to apply theory in different situations. The study of difference moves away from a strictly medical model to a more humanistic model. This humanistic model values listening and connection with the patient. Susie and Tonya listened and connected with the patient in the vignette. They used these skills as a starting point to give Barbara individualized nursing care. This type of care includes observing, comforting, presence, and touch. If you know the patient, then the care needed for the diagnosis can be individualized. These care skills have no reimbursement value because they are invisible and take some time.

The nurse educator must reflect on what each student brings to the culture of nursing education. Student nurses sometimes are socialized to think they have limited knowledge. Students require guidance to see how extensive their knowledge base is. This reflection examines the positive qualities a student brings to nursing situations. This process gives students the opportunity to know what it means to care as a nurse as well as knowing that the teachers care for them. Knapp (1994) says the caring curriculum creates an environment that promotes the growth of students and enhances their inner knowing. Students will learn to think critically and enhance their knowledge through the understanding of the other's experiences (p. 11). This understanding occurs with reciprocity becomes a form of existential experience. Student nurses go from knowing what the text says to being in a situation.

In my program's community course, students develop a therapeutic intervention for a population they have selected. Their population is based on the consensus of the group and in an area of mutual interest. Their selection is based on a treatment that the group wants to learn more about or develop. The students research how this intervention is needed in their chosen community. This learning activity increases the students' self- esteem and validates the power that they have within themselves.

One group learned of an increased incidence of diabetes and heart disease in a local community. They validated this through research and collaboration with local health care agencies. A local hospital donated equipment so students could check blood sugars and blood pressures at the local mall for area residents. The students and instructors involved were overwhelmed with the amount of people that participated in the health fair. They originally planned to be at the mall four hours but stayed an extra hour so they could see everyone. They learned collaboration with other professionals can be successful. The students developed referral skills and enhanced their teaching skills. These outcomes occurred because decreased structure and learner maturity are valued. The faculty members who planned this experience recognized that objectives of a course may be met in multiple ways. Students were able to develop their own learning goals based on course objectives. These students experienced increased self-esteem because they saw that this intervention had a positive impact on their community. The students learned they had the power to make change.

I see caring as already occurring within the nursing curriculum. This caring is student and patient centered in nontraditional settings. In order to facilitate care and prevent its hindrance, caring needs to be explicitly discussed and recognized within a group of learners. Caring is fostered through relationships and interactions. This process connects students to teachers and nurses to patients.

Dialogue and Interaction

As a feminist thinker and nurse educator, I reflect on my actions to improve and develop new practices. This reflection considers how students interpret and understand these experiences. Denzin (1989) says that individuals have experiences that involve meeting each other, confronting, passing through, and making sense of events in their lives (p. 33). I want to develop practical knowledge of how to sustain caring practices in faculty-student interactions and nurse-patient interactions. I always reflect on events in the classroom and clinical area. I guide students toward reflection that allows each student to see all the possibilities in a given situation. This process encompasses affective and often personal elements that are involved in learning. This consideration guides students to look beyond the textbook when planning care for their patients. Susie and Tonya looked beyond the textbook when caring for their patient with multiple sclerosis.

Benner and Gordon (1996) say caring practices must be sustained and the sustaining strategies must be worked out in public discourse. These nurturing strategies must be examined

at the interactional and environmental levels (p. 49). I believe the quality of these interactions rests on the educator‘s ability to role model caring to the student. This role modeling is one component of the caring interactional process. The nurse educator must role model caring so as to promote caring dialogue and practice that offers confirmation to students. Noddings (1984) speaks to the one caring as an educator who creates an ideal wherein another human is able to request, with expectation of positive response, an educator's help, advice, and assistance, and a promotion of caring as a moral ideal and ethical affirming. I think it is important for students to do reflective writings with their clinical assignments. Within this realm, they can ask for help and the educator can validate their positive attributes. In one of my courses, there is an older male student who is a displaced worker. John works very hard completing assignments and taking care of his patients. He struggles with communications skills and how he presents himself to others. Both I and another faculty member always try to commend him on his accomplishments. He will come to us for advice, and he always follows through with our suggestions. I want him to be successful because I admire his dedication and think he will be an asset to the nursing profession.

Nelms et al. (1993) use a qualitative approach in exploring whether students learn caring from faculty role models. The following themes emerged from interviews with student nurses. Student nurses learn caring from faculty role models as well as practicing nurses. Uncaring experiences in a clinical setting taught the value of caring to students. Students observed uncaring behaviors of nurses and these left an imprint in their minds. The participants related how the uncaring nurses were emotionally distant from their patients. These observations showed the students it was necessary to use caring behaviors with their patients. Nelms' participants thought these behaviors were achieved through observing, identifying, and incorporating what each participant saw as acceptable (p. 19). They thought this might involve how a nurse did a procedure and how he or she taught the patient about the procedure. In their observations, a caring nurse competently chose what action was in the best interest of the patient.

Forrest (1989) says from her observations that nurses incorporate caring behaviors in their practices that they see role modeled. I see role model caring as an excellent clinical teaching method, but the exact process or attribute of caring needed may vary according to context and individual. My caring approach with patients guides students as to how they should care for patients. My caring creates an environment that promotes the students' ability to learn in any given situation and stimulates inquiry. I usually see each assigned patient with the

assigned student. I try to validate each student's knowledge base and comment on the care that he or she gives to the assigned patient. With this process I emphasize the affective and caring components necessary to guide the technical procedures and how best to act on behalf of the patient.

Any given student in any moment may be faced with a new clinical situation that requires the application of didactic knowledge. The student learns how to do a Foley catheter insertion in the college laboratory but then must face doing it on a laboring patient on the obstetrics floor. A patient in labor is uncomfortable and upset. The contextual elements make the clinical situation unique and unknown and therefore, the student is nervous. The caring instructor recognizes the context doing the catheterization is different from what the student has done in a college laboratory. Foremost, the student needs to understand he or she has the instrumental abilities to do the procedure. The teacher anticipates the concern and supports the student by creating a climate that promotes the student's self-esteem. This climate encourages the student's capacity to exhibit care while learning technical procedures. The student is then able to reflect on what it means to be holistically present to the patient. This reflection is encouraged because the student feels care from the instructor. The instructor is the coach in a learn-by-doing clinical situation. The student nurse's use of the nursing process and choice of action are guided by the teacher. This is essential in beginning clinical courses because a student will struggle with what Schon (1987) calls "the low swampy ground." The technical rationality has to be balanced with caring rationality or the nurse is emotionally distant to the patient--the "gallbladder in Room 334." Problems will defy technical expertise and must address the human condition in a social context. A nurse needs to trust his or her intuition when dealing with patients. My students acted on their intuition with the women with multiple sclerosis. If one knows what is wrong with a patient and knows the patient as a person, you can intuitively sense when there is a problem or a defined need.

Schon (1987) states that reflection-in-action decreases anxiety in students and is facilitated by a trusting relationship with faculty. The student completes the technical procedure while approaching the client as a laboring patient. Schon's three methods for coaching can be applied to nursing situations like the catheterization of the patient in labor. The nurse educator sets the climate by his or her approach with the student that promotes the internalization of caring behaviors. The first method is called "follow me" and involves telling and listening and is foundational. The teacher demonstrates caring for and caring about and the student imitates.

The second method is "joint experimentation." The teacher and student jointly explore and analyze a situation. I feel this occurs frequently in beginning clinical courses. As a guide, the teacher helps the student frame the nursing concern and guides the student in the implementation of care. This process involves the exploration of various courses of action. The "hall of mirrors" is the third method of coaching. This method entails the student's attempt to acquire competence. The student practices what the teacher demonstrates and reflects or evaluates the action. The student sees how the clinical situation is unique for each person and implements care or change because he or she has tried to understand the situation from the patient's perspective. The student successfully inserts a urinary catheter in the laboring patient because she considered the factors that made the situation unique. Susie and Tonya offered the woman with multiple sclerosis authentic presence through their understanding of her psychological needs. These examples are desirable ways of interacting in nursing education that involve intelligent inquiry.

Noddings (1988) speaks to climate and interaction in the following statements: "In a classroom dedicated to caring, students are encouraged to support each other, opportunities for peer interaction are provided, and the quality of that interaction is as important (to both teacher and students) as the academic outcomes" (p. 223). A sense of community is created that leads to increased self worth of students. Community is increased through clinical groups and collaborative learning projects. This is accomplished if the educator presents himself or herself as a member of the class rather than the ultimate authority. I think that students appreciate this sense of collaboration.

Tebben (1995) conducted an exploratory study to examine factors that influence student satisfaction and success in a college anatomy and physiology class. The class consisted of 119 students enrolled at a small, private, Midwestern college. The most significant findings resulted from an examination of the survey data. The students stated that they experienced more satisfaction while learning when the teacher made a conscious effort to create community. This sense of community came when the students had an opportunity to both help each other and to experience help. The participants said that the process was facilitated when the teacher showed personal interest in the students (p. 341).

I guide students before a new experience to connect the theoretical concepts and their application to a particular nursing situation. Next, I ask each student to critique what they have done for their assigned patient(s). Students need constructive feedback that starts with positive

comments, since I believe students are harder on themselves. When I was a student, it was difficult when the instructor demanded perfection. Although I demanded perfection when I started teaching nursing, I have reevaluated this stance over the years. I give students credit for doing the very best when in a difficult or new situation. This perspective gives students a chance to reflect on their actions. They must deal with the realities of practice in order to arrive at critical thinking. Critical thinking starts with assessing the situation and planning nursing care based on the patient's needs or the clinical context. The instructor's guidance is available if needed by the student.

Beck (1991, 1992) defines the components of a caring nursing student-faculty interaction as attentive presence of the educator, showing respect and valuing the student, and not passing judgment on the student. This type of interaction allows for the expression of emotion and the sharing of experience. The student feels safe to express emotion, and the instructor appears more human when emotion is expressed. When experience is shared and discussed, those involved appreciate diverse perspectives. A more educative paradigm is permitted and involves more than training. This world view deals with the everyday realities of modern nursing and permits problem-posing. Students see how assumptions apply in the clinical areas and learn to search for the meaning behind words. I listen to students and then see if there is meaning behind their words. Student nurses learn to listen to their patients and evaluate the meaning behind their patients' words. Susie and Tonya examined the meaning behind the words of their patient with multiple sclerosis. They saw that her greatest needs were psychological and she needed some sense of control over her health care situation.

Garrison (1997) states that "inquiry mediates between being in some undesired present actual situation and looking toward a desirable future possibility of some better situation, some stable form, some end-in-view, that each of us strives to create through intelligent transformative practice" (p. 92). The unknown and the unexpected are the driving forces for inquiry in nursing education. Sometimes inquiry involves finding out what is best for the patient in a particular context and time. Students need to look beyond the obvious when attending to details or context. This process for the student nurses involves knowing the theory and knowing the patient. I do not think that this process of inquiry works when students are fearful of the instructor or question the instructor's competence. I think a caring instructor encourages the patient's confidence in the students. The student needs this to respond to the patient's physical and psycho social needs.

Garrison (1997) says the "moral task of caring is responding appropriately to needs, desires, and dreams of others." He relates how perception and responding to the needs of others are central to teaching, loving, and logic (pp. 56-58). Teaching-learning activities with reality-based objectives are less prescriptive to certain outcomes. These objectives facilitate learning which reflects the competencies of the graduate nurse and are practiced oriented. The task of the nursing instructor is to value each student with loving bestowal so as to create an educative environment that connects didactic and clinical knowledge. This environment encourages the student to use new knowledge in new contexts. It is opportunity to see connections and make judgments based on intuition. I think this is frightening and rewarding at the same time. The key element is a heightened perception that permits one to see relationships behind assumptions and to question them if needed. Students have to be encouraged to see those relationships and make those connections. Noddings (1988) encourages students to support each other and promotes peer interactions. The quality of the interaction is as important as the outcome, since it leads to a sense of community and occasions for caring for students and patients.

Connection and Community

This perception promotes conscious connection with others and is an occasion for caring. This consciousness guides and directs what the learner does with the information from lecture. It allows the student to use the contextual elements that he or she sees to plan individualized care in the clinical area. It is how the student finds meaning and uses that meaning in actual situations. Nursing care becomes more than mundane instrumental tasks. It involves seeing the patient as both a person and someone that could be a member of your family. The patient's needs are valued and considered while providing competent care. There is involvement with the information and reflection on the meaning behind one's relationships.

Clayton et al. (1991) state that connection occurs before caring does. Connection is seen as the transpersonal experiences and feelings that lead to attachment (p. 155). Watson (1985) says that in any human encounter there is the possibility for a caring occasion. This occasion is a focal point in space and time in which experience and perception take place, but the actual moment has a field of its own that is greater than the occasion and the moment itself (p. 116). This field of interaction involves the instructor, the student nurse, and the patient within the context of nursing. I know I experienced this with Barry, the teenager with the neurological impairment, and the student nurse, Cassie. I knew this had to be overwhelming for Cassie, and she immediately made a connection with Barry and his mother. There have been other moments

with Cassie where we made connection during a caring occasion. This sharing of experience has allowed us to be more comfortable with each other. I have had Cassie for two semesters in separate clinical courses. She is always willing to help others when she has completed her assignments. While with a staff nurse, she was taking vital signs and a patient complained of pain. She volunteered to give this patient an injection for the pain. Cassie and I went to the patient's room with a prepared injection. She identified the landmarks and prepared to give the injection when the patient starts this "blood-curdling" scream. Cassie looked horrified at me. I reassured Cassie that she is doing fine, and I asked the patient if there is a problem. The patient responded, "Honey, I just like to scream." Within this interaction, I tried to make a connection with Cassie and the patient that prevents reductionism. I knew this was a terrifying experience for Cassie She thought that she did something wrong. I attempted to balance Cassie's needs as well as the patient's needs. Cassie and I had a similar experience in another clinical course with a two-year-old who was receiving an antibiotic injection for an ear infection. Cassie was calm and collected with perfect technique while giving a crying and scared toddler an injection. They were two similar yet different experiences which we shared in different moments of time. Cassie came to help Tom, another student nurse, take care of his patient who was in isolation for a viral infection. Tom's patient is a two-month-old and grandma was holding the baby. Tom and Cassie were making the bed. I noticed the baby was following Tom with her eyes and watching him. Later in the conference room, I commented that this baby was very alert and watching Tom. Cassie said, "The baby is stimulated by Tom's hair." Tom has dyed his hair bright canary yellow. Tom laughed and said that he is trying to cover his "salt and pepper" hair. Maybe it was funny in that moment and time because of the way that Cassie delivered it, but it was a connection that brought our group together.

Each person is important in the group since a sense of community is evolving. These meetings involve deciding how to be and what attitude to take with each other. There may be sharing of thoughts and ideas, and yet silence may be embraced. This silence allows one to think about one's initial reaction and its impact on others. This process encourages sharing individual experience which leads to understanding that there may be different paths in problem resolution. The teacher facilitates or encourages connection and the climax of this connection is a caring occasion. These caring occasions create an environment that is conducive to learning

There are personal factors that promote connection and caring and center around values and feelings. The nursing student needs to learn to reflect on the social political environment

and how it impacts health. This reflection makes the client the center of the curriculum and not the discipline. Nursing students need to develop an understanding of how different environmental context impacts a person's experience of health. Compassion, concern, and connection are dependent on the context of the situation for the patient and for the nurse in that moment in time. The student must learn that the patient and nurse cannot become mere objects in this incidence.

This involves examining the particulars of one's lived experiences. These particulars are elements of the practice setting, procedures, rules, relationships, and the characteristics of the social environment. Students need to learn how their education connects to the social environment. The teacher can facilitate this by keeping current in issues relating to practice. This process evaluates the curriculum and assists in improving teaching methods. The faculty at my school did this several years ago when we refined the curriculum. Several faculty members were practicing as clinical specialists and advanced nurse practitioners. We noted that patients were not necessarily in the hospitals. We worked on providing our students the opportunity to care for patients in multiple community settings. I think this process makes our curriculum more person-centered rather than being content-driven and procedure oriented.

In my Nursing Care of Children course, students spend time in the hospital caring for children who are ill. The Nursing Care of Children course also encompasses well child care and care of children who are at risk because of developmental issues. Our students go to local Head Start Centers for a day with their clinical group and instructor. It is an opportunity to examine health care concerns in the preschool period, and the student has the opportunity to provide anticipatory guidance for the teachers. Each group member develops a teaching plan on a common health concern in this age group. Some of the topics include scarlet fever, chickenpox, ringworm, scabies, lice, lead poisoning, and child abuse. The group teaches a health lesson from the "I Am Amazing" series. Last year, the lessons centered around healthy bodies and the five senses. This year our health lessons are on safety and healthy nutrition.

We also are working on a special project called "Hands Are Not for Hitting." After the children have an opportunity to trace their hands on a placemat, we talk about positive things that one can do with one's hands on the opposite side of the placemat. The nursing students can see some actual social issues related to ending family violence. This intervention prevents violence rather than treat the consequences of violence. Our college will laminate these placemats for the children so they can use them in their homes. The Head Start visits provide the

student the opportunity to learn rather than be taught about preschool development and health problems. It is an opportunity to interact with children and to see how nursing can impact their development. This relationship with Head Start children allows the nursing students connect with a particular age group and how health concerns impact them. This experience shows the students that our college is communicating and addressing needs in our community.

The nurse educator must place emphasis on how he or she interacts with students and patients. The process recognizes learning is personal and private and may occur in obscure circumstances when you least expect it. It is important for the teacher to recognize learners can learn different things from the same experience. Learning outcomes are intricately connected to student teacher relationships. Caring is learned through relationships that allow the student to internalize caring behaviors.

It is within caring occasions that individual learning occurs while a sense of community is created. This sense of community promotes a climate of caring that nurtures those involved. Hughes (1992) conducted a qualitative study involving student and teacher interactions. The results of this study describe a caring climate as one where stress and anxiety are acknowledged. A caring climate gives students the opportunity to express opinions and concerns without reprisal. The participants of this study interpreted caring climate according to the instructor's behavior. Caring faculty behaviors were described as uplifting, and the students thought they could overcome anything. Students in the study said they dialogued with faculty members who role modeled caring behaviors and conveyed presence. Uncaring faculty behaviors negatively impacted the participants' self-esteem. It is through community that better relationships are developed between student and teacher and patient and nurse. It is within these relationships that caring behaviors enhance an individual's capacity for growth and a culture of caring. Students who learn in a caring environment will learn to use caring when doing nursing interventions for patients. The individual is not a passive receptacle subject to the teacher's control. Knowledge becomes valuable to the student when it becomes a part of their lived experience.

Jim's first experience with children was in my Nursing Care of Children practicum course. This course encompasses few technical procedures but involves communication with the child and family. This communication is important because student nurses are often fearful since handling a child is different than an adult. Some children are unable to tell you exactly what is bothering them like an adult can. Jim wrote in his clinical journal that he learned how to

talk to children during the clinical course. He stressed how you have to be specific and use common language when talking to them. It is important to find common ground with them. It seems if you find something in common with them, then they trust you more. This understanding allowed Jim to connect what is happening around him so he could provide holistic care to his pediatric patients. This journal assignment fostered dialogue and allowed Jim to make meaning out of his clinical.

Dieklmann (1990) speaks of dialogue as engaged listening and sharing of histories. She says that dialogue involves seeing the curriculum as involving our lived experience and just a puzzle to be solved (p. 301). I think the author is saying that not everything about curriculum can be analyzed and made explicit. Socialization is a hidden part of the discipline and the curriculum. Reflective activities like narratives and journals allow one to make sense of experience. The individual sees how he or she has grown as a person and professional and how particular experiences help this process. Reflection allows the individual to see the particulars of a situation. This process also shows the complexities of human experiences that occur in nursing and health care. Making sense of experience assists with role socialization and development.

I think it is important for students to talk about the woman with multiple sclerosis. The students see that curing and technical proficiency is not always what some patients need. Susie and Tonya knew that Barbara needed their presence because their presence allowed them to listen to her concern. This reflection on a situation connects new learning with experience so as to shape future learning. These students were able to individualize theoretical considerations to meet Barbara's needs and address her vulnerabilities. They saw how important it was for nurses to address the individual's needs within the community and the needs of lay caregivers. I could only lecture from two preschool chapters in our pediatric texts. I see the Head Start experience as more meaningful than lecture. It allows students to reflect on the classroom knowledge and apply to actual children.

Knowledge development must consider how educational experiences are affected by social institutions with traditions. These traditions involve socialization that seems mundane and invisible in the profession. The acknowledgment of these traditions within nursing raises awareness about rituals and traditions and what can be learned from them. This awareness moves nursing socialization within the legitimate or illegitimate curriculum. Nursing is taught and practiced under guided supervision so students can go from novice to expert nurses.

It becomes very important to consider what it means to be a nurse in a clinical setting. A clinical setting is filled with ambiguities and varying contextual elements. These realities are not addressed in a textbook. It has been my experience that influential learning occurs when I relate or interact with students. The student nurse sees a patient as the patient is and has to assess the patient's needs at that moment. The student nurse must then implement and evaluate a clinical intervention. This process requires a cognitive recognition of what is important to the patient emotionally and physically.

This attentive presence is guided by caring and enhances the nurse's power of perception. Perception is guided by a caring stance that allows the student to apply theory while giving individuals patient care. This process shows each student that he or she has personal power in clinical situations. This power centers around impacting the behavior of others. It centers on doing something to initiate a change in the behavior. The power comes when the student realizes that he or she can meet the patient's need for care. A student who successfully masters this process will facilitate empowerment in his or her patients. It may involve developing a teaching plan for a new diabetic patient while considering the Appalachian culture. It could involve simply listening to a wife tell stories about her comatose husband. Most importantly, it is about the power to make a difference in someone's life and the power to appreciate each person's differences.

My students cared for a very verbal little boy who had two mothers. The mothers were equally involved in his care. One student commented that this situation was a strange one. Another student reflected the little boy is a lucky child to have two mothers who loved him dearly. This discussion gives us power to discuss differences and how each person can learn from the experience. The group learns that the traditional family does not always exist or is in the best interest of the child. Situations are only strange because individuals make them strange. Unwillingness to explore different perspectives or context make individual situations strange. In order for students to master this process, it is important for the educator not to abuse power with students.

Farley (1991) says that nurse educators often play "power games" with students after they have done their very best. As I read her article, I thought about my practice of teaching nursing skills. As a nursing student, I remembered having trouble putting on sterile gloves in the school laboratory. I had to get in front of my class and put on gloves over and over again. I thought that I would have gotten it right, but my instructor yelled at me and called me stupid. I

had trouble making sure that the gloves covered the cuff of my gown--I wanted to quit the program. I think in my early days of teaching, I got impatient with students. I did not recognize when they did their very best.

I implemented Farley's ACE model of clinical teaching. She says that nurse educators need to acknowledge, create, and empower students (p. 91). I use this to avoid the control, order, and predict (COP) model which causes such stress for students. When faculty offer students nonjudgmental acceptance, then unproductive moments can be turned to productive moments of learning. If I sense students are fearful of me or if they struggle with a procedure, I will tell them how I had difficulty with putting on sterile gloves. This story eases tension and fear. It shows me as human being who has an appreciation of their position. This is a process that addresses the illegitimate, hidden curriculum. Curriculum must also be legitimate and explicit.

Bevis (1989) says the legitimate curriculum is acknowledged and used by the faculty. The illegitimate curriculum teaches caring, compassion, power, and its use and accountability (p. 75). These are issues that involve insight and patterns that emphasize process and the holism of the individual participant. This process embraces difference within a caring learning community that fosters individual agency in each person. Agency involves competency and self affirmation that is encouraged through dialogue and being open to the meaning behind a student's behavior. This fosters the student's critical thinking which is vital to functioning in a changing contextual health care environment that cannot be addressed in behavioral terms. It is through this critical thinking that a student sees in his or her own terms what he or she needs to know. Learning is educative since it addresses relationships based on theoretical concepts and allows for intuitive decisions. Bevis (1989) also describes the hidden curriculum in nursing education. She says faculty are often unaware of this curriculum. It involves the messages that are given by the way faculty teach courses. It involves the how and why of interacting with students and staff. It includes priorities that are set in the classroom and is subtle since values and attitudes are used (p. 35). Faculty who are aware of the hidden curriculum encourage questions from students and foster exploration and reflection. Martin (1994) supports this concept when she says that a hidden curriculum involves learning states. A learning state is an unintended learning outcome. She explains that faculty need to examine what is learned from the practices, procedures, rules, relationships, and physical characteristics of a given setting. Nursing faculty need to be consciously aware of how internal and external factors impact the

learning environment. I was thinking about what this means to me. I was stopped in the hallway by Molly several times. She wanted to review the test she failed by three points in my class. I really did not want to stay until five when her class was over. I looked at her and knew she was upset. I said that I would stay so she could review her test. My initial impression was she did not do well because she did not study. Molly came promptly to my office, and I saw my initial perception was wrong. Molly was so concerned that she would flunk out of the nursing program because she gets very anxious with tests. Molly is probably studying so much that she is not caring for herself. She is not doing the things she likes to do. She is not going out on dates, and she is not exercising. I told Molly to take care of herself and to concentrate on small successes. She is constantly concerned she will fail, so she is not seeing anything positive in her life. She starts to cry because it is Valentine's Day and she does not have a "Valentine." I cannot do anything about the Valentine's Day issue, but I saw why it is important to her. I am glad I stayed and talked to her. In some small way, I made a difference in her perception of herself. I could have been an external determinant if I had left before we had a chance to talk. The teacher's approach is important in a caring curriculum. This approach reflects what the teacher values in education and practice.

Linking Dialogue and Role Modeling

I see the caring curriculum as a combination of the illegitimate hidden curriculum and the legitimate acknowledged curriculum. The caring curriculum centers on dialogue and role modeling. This dialogue is dependent on the teacher being perceptive and receptive to students while they are learning. Noddings (1984) defines modeling as the enactment of behaviors that indicate to another that one is a caring person (p. 178). Caring is in the perceptions of the recipient of the behavior. I thought I was role modeling caring behaviors, but I was not entering into dialogue with my students. I have struggled with this apparent paradox with my students. In this struggle, it has become apparent that presence is key to the perception of caring. Garrison (1997) speaks of,

> teachers as moral artists; they, too, have their potential actualized by the students and by the creative activities in which they engage that allow them to respond in ways that promote the growth of their students. In caring for others, we not only come to know ourselves but we must explore our interests, develop our abilities, and try out new ideas and attitudes (p. 45).

This thought has been in the deep recesses of my mind as I tried to be a caring professional. I always felt I was caring, but this process has made me examine it more closely. Nursing speaks to caring but the profession does not tell how to be caring. I fear it is an expected outcome with no clear directive as how one should be caring. I say I am caring, but am I really caring to my students? This process comes to fruition as I search the theoretical aspects of caring and then try to actualize them in my practice. This is an ongoing process and requires being open to personal growth and change. It requires redefining what is important and prominent in my life. I began to write poetry about my students to aesthetically express what I see as important. I feel that my relationships with my students over the years have made me a better person. Any activity that makes you a better person promotes growth, and through growth ideas and attitudes are changed and expanded. A key element is dialogue that contains presence. I see presence as being fully there when interacting with students. Sometimes it is easy to get caught up with what happened at home last night or what is going on with your family. An individual forgets about presence at that particular time with a particular student. Student-teacher interactions will lack dialogue and personal connection. The receptivity that comes with presence will be lacking in these interactions. The teacher will have difficulty in understanding the student's needs and reality.

Noddings (1984) says that the person who cares must be able to receive the other person's reality and put his or her interests aside to understand the other's reality. This statement supports the notion that learning is dependent on context. Educators may not always understand the context of the situation for the individual student, but dialogue allows the educator to appreciate the student's perception of his or her reality. This requires presence on the part of the instructor. It is easy to show up for class or clinical with thoughts of family or social activities on one's mind. If this happens, then it is difficult to be there for each and every student.

Tagliareni (1993) says that it is important for faculty to be there for students, to care about them, and spend time with them. She states that this means that the educator and the student must be willing to be changed by the experience (p. 6). The student must be willing to be changed by the experience and must be willing to keep trying even when skepticism prevails. It requires effort to be aware of individual students and what each one brings to a learning environment. This places value on the student as he or she is now and not on what he or she may become.

Nola, a fourth semester student, came to me and asked for change in her Adult Health clinical rotation. I started to say that I cannot accommodate you because I need to limit the number of students. I noticed her eyes were beginning to water. I asked her to come talk to me in my office. I wondered what was going on with Nola. She is an excellent student who gives outstanding care to her patients. Her widowed father had just had major surgery in Bristol, Virginia. She needed and wanted to see him for more than a few hours. I made the schedule change and made the necessary adjustments. I asked her how her father was doing over the next several weeks. On graduation day, she thanked me for being there for her. She was very complimentary about the nursing program. She suggested to the curriculum committee that faculty do more to increase self-esteem in students.

Student Teacher Relationships

Halldorsdottir (1990) says that the first step of the professional teacher-student relationship is the initiation of attachment. This phase promotes reciprocity that encourages mutual acknowledgment, the second stage of this relationship. This stage validates the uniqueness of each person and progresses to the third stage which involves developing boundaries in this relationship. The boundary setting allows for professional intimacy where the student feels safe enough to ask questions and to negotiate learning outcomes. Negotiation of learning outcomes is the fourth step of this relationship and involves dialoguing. The teacher sees the student as an individual and is supportive without fostering dependence. It is within this stage that students develop goal directed work. Halldorsdottir says that this leads to the fifth stage where the teacher is able to understand the student and his or her world. This understanding promotes independent thinking which leads to the last stage which involves graduation. The author says that at graduation the caring teacher invites the student to a different relationship--a relationship that is close to friendship and is situated in the academic world (pp. 99-100). I think that this relationship is closer to mentoring. I see mentoring as way of being in the professional world. I think Nola and I entered into dialogue the first year of the program. She flourished in one of the collaborative projects that replaced the health promotion paper in the course Nursing Care of Children. I acknowledged her creativity in class projects and how well she cared for her patients. She was a student that met the challenge when posed with a problem. She was a respiratory therapist prior to entering the nursing program. I always encouraged her to call on her experiences to enhance her nursing goals. This as how we developed mutual respect for each other.

I have studied and scrutinized this concept of caring relationship within the curriculum. I think caring dialogue is centered within clinical teaching. It is with clinical teaching that I have come to understand my students and the contextual elements of their lives. The key element involves an interpretive process which leads to understanding the meaning behind what is experienced. It is in the clinical area that the student has a variety of experiences that cement what they have learned in the classroom. While you can read and be tested on how to care for a child who has diabetes, it really comes together for the student when they care for a child with diabetes and see how the disease impacts the child and his family. A student may have a child about the patient's age and remark about how well the child does in a certain activity. The student works with the parent to adapt the child's meal plan so they can benefit from the school activity. It is within these moments that student and teacher discover learning is more than learning technical skills. I believe these moments are important in clinical teaching. I believe more expert teachers are needed in undergraduate clinical nursing education.

Clinical Teaching

It is clinical teaching that cements didactic education and centers on contextual understanding. The expert teachers should be those who are doing clinical teaching, but often novice teachers are hired for clinical courses. An inherent paradox exists with this statement. The novice teacher may have excellent clinical skills but lack teaching experience and advanced degrees. The expert teacher may be a good didactic teacher but lacks clinical skills. This lack of clinical skills comes from being away from the clinical area and in academia. Therefore, a crucial element is that the teacher must be clinically competent. Clinical competence requires a large investment of time and energy, and it is difficult to balance this with research. The other side of this dilemma is that adjunct faculty are often used to teach clinical courses. Dialogue requires a reflection of the inherent paradoxes within nursing education. I am not sure most adjunct faculty can adequately address this issue. Doing clinical allows an educator to relate clinical issues to classroom discussions. Connection with students is enhanced by the shared experience in the clinical area.

Reflection is my constant companion while I write and while I practice as a nurse educator. How is it that reflective dialogue and clinical competence come to be at the center of a caring curriculum? I see dialogue as a crucial element of learning in the clinical setting. Dialogue is the center of some caring relationships and fosters role modeling of caring behaviors. It is within the clinical area that I have been able to dialogue with students. It is in

clinical teaching that the quality of the interactions has been as important as the learning outcomes. It is easier to create a sense of community in the clinical area. It is always a unique and context driven experience, and it is where I have seen students grow and develop before my eyes. Montgomery (1993) states that caring is expressed by participating in an experience with a patient. She says that it is contextual and dependent on the intensity of circumstances and shows the power of communications (p. 20).

As I am walking down the hall in our administration building, a secretary asks me if I know anything about contractions. Yes, I do know about contractions, because I am presently teaching an obstetrics clinical group. I walk in the room and meet Jan for the first time. Jan is having contractions and is expecting her second baby any time. I reassure Jan and tell her that she is handling the contractions effectively. Since I have students on the obstetrics floor, I will probably see her when she gives birth. Jan says that she does not mind if I assign a student with her for the delivery. I ask Connie, one of my older students, if she would not mind being with Jan when she is admitted. Jan is a single mother and her father stays with her daughter while Jan's mother is working. Connie stays with Jan through the late stage of labor and during the delivery. I know Connie and Jan connected and Connie was a support person to Jan. Connie thanks me for this wonderful experience and how much she learned from being there with Jan during the delivery. Jan keeps thanking me for assigning Connie to her and how helpful she was to her. I am overwhelmed because I am doing my job. Connie shows caring by being with Jan and anticipating her needs for support.

With clinical teaching, I see elements of creativity that I do not necessarily see in the classroom. This environment requires the student to think about his or her thinking. This metacognition promotes the critical thinking while caring for patients. Clinical learning promotes role socialization that cannot be learned from a book. Role socialization is promoted through caring relationships with faculty and staff nurses. I think this is an aspect of the hidden curriculum that must be embraced and openly recognized.

Personal Vignette

I often have personal revelations when I fly back to West Virginia after attending conferences. While my plane has left San Diego and is flying over the San Diego harbor, and I am thinking about when I will see the West Coast again. My students come into my mind, and I am glad to be going home. I am coming home to what gives me a sense of worth and a connection. These feelings are something my friends and family do not quite understand. It has

not been easy staying in this rural, mountainous region and a small town where everyone knows your business. Sometimes leaving seems the easiest thing to do. I have grown personally by staying and changing. This change has evolved from my personal growth as an educator. I am thinking about the college as the pilot orders the flight attendants back to their seats. The orange juice I am drinking goes flying across the tray table when we hit a pocket of intense turbulence. I try to concentrate on my clinical group I will have tomorrow and my work-study students. I will arrive later in the evening in Charleston, West Virginia, and will drive about ninety minutes before I arrive home.

Lynn is my work-study student who just graduated from the practical nursing program. She is several years older than the other students in the clinical group. Lynn's mother was one of the first nursing graduates at the college. Lynn is struggling with some of the support courses when she comes and asks if she could volunteer Thursday afternoons in the nursing center at the college. She said that she is going to be in my Women's Health Practicum in October if she stays in the nursing program. Lynn is very upset and she talks frequently of quitting. She was in the associate degree program in the late 1970s. She dropped out of the program then, although she continued to work in hospital settings. She is raising a son with Down's Syndrome and her husband is disabled. I attentively listen to what she was saying because she is so distraught over the stress in her life. I kept thinking what is going on with her. I knew she was first in her class at the vocational school and had graduated in August. It seems the general mathematics course is very frustrating to her. Judy is also a volunteer at the college's nursing center and is working with me that day. Judy volunteers to help Lynn with some math problems. Judy has already had the course, and she makes plans to meet Lynn. Later Lynn tells me how helpful Judy is. Lynn says that she never thought to ask Judy for help because of the difference in their ages.

Over the next several weeks, I listen to Lynn and validate what I see as her positive attributes. Lynn seems to blossom when she is helping me in the nursing center. We talk about how she continues to pursue her dream to become a nurse like her mother and how the path is complicated for her. Lynn stops talking about leaving and seems more confident. It is something that happens over several weeks. She comes faithfully to help me every Thursday afternoon in the nursing center, and I listen to her and offer suggestions as how she should approach things. I encourage her to take the advanced placement examination for pediatric nursing for the spring semester.

When we start the Women's Health Practicum, Lynn is supportive and encouraging with the younger students. She shares with them some of her experiences with patients when she was doing clinicals for the vocational program. This is helpful for the beginning students because they have not been with patients. She is role modeling the way I was with her. Early in the semester, I seized the opportunity to be Lynn's guide on her educational journey when I tried to understand what she was experiencing. This understanding comes from actively listening to her concerns related to her age, family's needs, and adjusting to college classes. She came and offered her help in the nursing center because she needed to be connected both to someone and the nursing program. I think the nursing program may have lost her if she did not have that sense of connection. Thoughts of Lynn and others take my mind off the "bumpy" plane ride to Washington.

At Dulles Airport I sit in the busy commuter terminal awaiting the boarding call for the small commuter to Charleston, West Virginia. I think about the hidden curriculum and the messages my profession conveys to others and its students. I am wondering if I can ever express what I feel to be the truth about teaching. As with Lynn, I know sometimes it takes being a good listener to understand the student's reality. It is when you begin to understand the students' reality, that you begin to dialogue with students . I think when you try to understand the diversity of students, you can teach and connect with them. I see difference as enriching and not something that needs to be mellowed or shaped into the teacher's way of thinking. An examination of difference has always given me a fresh perspective on my environment. I look at the quiet, dark sky and the misty mountain ranges, and think of home. I care about my nursing students, and I think I understand some of the challenges they face. I hope I am giving them the message that what they are doing does matter to me and others. I stay because I care about what I do and the area where I am doing it. The crux of this caring comes from practicing from a heightened consciousness. This allows me to reflect on personal experience and connects individuals to each other and to a profession. I developed a connection with Lynn and Judy. Judy is going to graduate this year and plans to continue her education. I have seen her grow professionally as a nurse and as a person. When Lynn needed to take a leave of absence from the program, I offered her my help and tried to convince her to stay. Lynn is struggling with some of the same issues that I had early in my life. I understand she needs time to establish her own identity after some troubling marriage issues. While I respect her need to address these issues, I think coming back to school is one method for her to care for herself.

Henderson (1997) defines consciousness-raising in nursing practice as the process of being increasingly aware of the various internal and external constraints that impact professional and personal freedom. Fonow and Cooke (1991) place emphasis on the fact that the learning outcomes from conscious-raising increase professional insight and increase activism. I want students to see what is learned in the classroom influences how they are with others. What is learned is internalized and should change how they live in the world. My priority is to appreciate the uniqueness of each student and what they have to offer. I look for ways to show students they have inner knowledge that will guide them in new situations or with different problems. This is accomplished with the encouragement of questions and the fostering of reflections on experience. Students spend time reflecting on real situations and thus generate solutions for current concerns. In the validation of inner knowledge, old assumptions and beliefs may be altered.

This examination shows how dialogue allows one to reflect on the hidden curriculum and how this reflective process promotes caring. Watson (1989) says that caring and teaching-learning are human processes, not products or commodities. A caring curriculum provides a transformative paradigm because moral conscience guides knowledge and skills (p. 55). Such a curriculum must express a conscious intent to see it from the student's perspective and to examine how teaching methods lead to certain learning outcomes. The student then engages fully in the learning experience. The benefit to the teacher is in seeing the student's growth. I will also propose we have often treated caring as the null curriculum that we have described with great rhetoric but never implemented. Nurses talk about caring but never give any direction about what it means to care or how we learn to care for others. Caring is nebulous and a word often taken for granted that is tucked away in a philosophy.

Several years ago I thought I was caring or at least attempted to be caring to my students. I was going to graduate school and had two teen-age sons at home. While I am wrote about a caring nursing education, my student evaluations said I was not caring. I was pretty involved with myself and not open to others. I needed to examine the incongruence between my perception and the realities. If I was to grow as an educator, then I needed to be open to change. To change, I examined my actions and how they created a hidden curriculum. This examination allowed me to see what messages I was sending to students. I changed the environment I created by altering my practices and procedures. It is more about responding to individualized contexts than altering processes. In this contextual process, I have learned being a better teacher involves

being receptive to the needs of others, even if that requires one to change. I also require my students keep reflective journals because they encourage me to be more attentive to my students. Dialogue through the journals challenge domination in the classroom.

This process makes the teacher reflect and learn from his or her experience. I see writing as distancing students from the experience and allows them to reflect on what they have not considered. The journals promote visualization of meaningful relationships within the clinical and theory courses. I learned from my students' journals what they perceived as their learning needs and concerns. Sometimes it differs from my perceptions. I am able to see each student's stance or perspective and how they perceived different situations that may differ from my perception. The students' self-worth is validated while students learn to reach their potential in nursing. The journals allow students to return to the experience and attend to emotional responses that occur with the experience. The process allows them to connect new thoughts with old thoughts and allows for validation of insight. I see this insight as the ability to think critically in any given situation. It involves responding to each individual patient's needs. It means the students need to engage in the reality that surround them.

Conclusion

I use narrative to articulate my everyday practice as a nurse educator. The use of narrative allows me to interpret my experience and validate growth in myself and my nursing students. Sometimes the process needs to take precedence over the task. I see caring practices as evolving from our relationships and discourse with others. This discourse should be challenging for the student while at the same time not promote the fear of reprisal. These interactions may seem inconsequential moments but are significant when they express authentic presence. These moments may show an individual does not have all the answers, but is willing to work on a solution to a concern. I see this as leading to a caring rationality that guides technical competence. This caring rationality can recognize a new problem or a new situation and allows one to uncover knowledge in this situation. This process shows an awareness of interrelatedness and guides a sense of responsibility in the educator and students. I think this sense of responsibility encourages connection and concern with others. In clinical courses, nursing students come together as a connected group, and students learn to listen to their voice and others within the nursing community. I see this as a sharing of ideas and information with each other that promotes critical thinking. They learn what is right in any given nursing situation is dependent on the context. The woman with multiple sclerosis needs someone to look beyond

the medical model and to examine the “here and now” of her situation. It is the same for Barry, the sixteen-year-old with the serious neurological problems. A caring curriculum is the process by which faculty implement didactic and clinical courses. This process makes the client the center of the curriculum as faculty guide students while they care for patients. This process allows one to examine individual differences and act in the best interest of others. There will always be difficult patients who pose difficult moral and personal issues. A sense of community without power games fosters dialogue and shows the individual student, nurse, or patient he or she is not alone when struggling with these issues.

Chapter Five: Concluding Remarks

My dissertation strives to give voice to my beliefs regarding the vital relations among caring, nursing, and education. As I learned to give voice to my past, the use of narrative permits me to understand evidently or work through the various passages of my life. The use of narrative has allowed me to engage more fully in my caring practice. A look back in time is historical in nature and permits one to see experiences and behaviors from various perspectives. This dissertation includes vignettes that represent a mosaic quilt of what I believe is caring in nursing education. In the center of this mosaic quilt lie my commitments to caring and feminism. These commitments set the stage for a discussion of my assumptions about caring as well as how I strive to implement them in nursing and nursing education. I have come to understand the essence of my beliefs about caring center around my Great Aunt Margaret and my mother. My mother and Margaret preserved and facilitated my growth as a woman and a professional. My core assumptions about feminism emerge around personal meanings involving my relationship with my father. My father strongly believed women should be educated and yet he raised me in ways I now find were oppressive. My father said he wanted his daughters to have an education although I am not sure he was aware of the liberating effects of education.

I wanted to practice professional nursing. As I became involved in my profession, I saw I was capable of making decisions and accepting responsibility. There were times my father thought I was not capable of doing certain things. For example, one afternoon while I was driving through Fairmont in a snowstorm he made me stop the car and change drivers because he knew he was the better driver. He saw his sisters ask their husbands for permission to do certain activities. My father was always making decisions for my mother. I was always bothered when my mother was passive with him. I learned this script in my family of origin. I was socialized to be subservient, but my education made me question this socialization. I realized I was capable of making decisions without assistance, although while growing up, felt my family and I were different from my peers and their parents. After marrying a doctor, I convinced myself I would no longer have to worry about being different since we left West Virginia and the world my family lived in. My family thought I would now be secure for the rest of my life. Security has to come from within an individual and not from being an obedient wife. However, it would take me time to learn this lesson. Before I learned this fact, I had to come to terms with the dichotomies in my life. My father was sending me different messages. I had to learn I was a

strong woman and could make my own decisions. I had to risk the security rather than stay in a marriage where I was losing myself. These issues contributed to the assumptions I was developing relating to feminism, education, and caring. My vignettes are significant in how they prepare me to acknowledge new theoretical constructs and articulate my beliefs. One's beliefs guide how an individual behaves in this world. My writings are a method to give voice to the significant moments of my life. By giving voice to these moments, I can come to care more not only for others but about what I do and who I am.

Caring is a way of being with others. It involves being open, compassionate, sensitive, and includes self-awareness. Caring is still considered women's work, invisible, and undervalued. My mother and Great Aunt Margaret were very caring women who were treated oppressively by the significant people in their lives. As I was growing up, I was nurtured and cared for by them. I began to question how they could be so good and treated so unfairly. Here, I am questioning how they were treated and not realizing I am also placing them on the margin.

Growing up, I realized I was different, and I tried not to be different from others. I internalized the values of the dominant culture and was not aware of my true self. I was still developing, evolving, and becoming. I wanted to become different from my family. This is one of the reasons why I embraced a marriage that was not good for me. At the same time, I did not believe I had the right to be global or challenge my horizons. I thought my only option was one of the caring professions, like nursing, teaching, or social work.

I entered nursing at a very authoritative and oppressive time. Nurses were still considered the physician's handmaiden. The nursing journals questioned why nurses gave up seats for doctors, asked if they wanted coffee, and waited anxiously for their next word. Caring theory was not explicitly explored. In the middle to late seventies, the early nursing theories about caring were published. In the seventies, I was very involved in providing nursing care and caring for others, but caring for my self seemed of lesser importance. Over the next several years, nursing and nursing education changed as I changed. I believe the most influential events in a life are those that occur in relationships to others. This dissertation helps me document the significant and inconsequential moments of my life history. These moments explore what happens in interaction with others. It enables me to reflect on my reality along with how it validates and helps me understand my professional work.

I read Jean Watson's Theory of Human Caring while working on my master's degree. It did not seem like something to include in my theoretical framework at that time. Caring was the

essence of nursing and advertisements said caring was the heart of nursing. I was already teaching nursing, and I assumed everyone was caring so why bother studying it more. My caring views were in limbo until I arrived at Virginia Tech in the summer of 1994. My advisor suggested a course called "Analysis of Educational Concepts." I was very scared because it appeared to be a very difficult course, and I was unsure if I could handle the difficulty. This course introduced me to Nel Noddings and feminist concepts. I then re-read Jean Watson with new enthusiasm. I saw nursing as not having sole ownership of caring concepts. I started to see how my life experiences reflected the need for caring to be gender sensitive. I experienced a sense of community and connection with others in this class. My master's degree courses gave me some sense of community, but I did not experience the connection. The professor in this analysis course made the difference through his use of dialogue. I started to question and really began to examine what I believed about caring. Later, the same professor introduced me to Jane Roland Martin and Changing the Educational Landscape. In the chapter entitled "The Contradiction and the Challenge," Martin (1994) talks about Virginia Woolf's Three Guineas where there is a bridge connecting the private and public world and the world of female and male. Martin retells the story of the bridge and says there are two roads after one crosses the bridge and one leads to higher ground and the other to lower ground where the caring professions are. I stand on the bridge looking at higher ground and evaluating my life for a very long time. I am trying to figure out how to balance critical thinking and rationality with care and concern. I read this chapter every night because I am on the bridge mentally with my Great Aunt Margaret and my mother. Martin asks us to find a gender sensitive ideal where all individuals are free to exercise their intellect.

My mother died twenty-one years ago, but I feel like she is always a part of me as well as my Great Aunt Margaret. I have been taking mental trips to the bridge looking at the high ground. Since my mental trips, I have captured my Great Aunt Margaret and my mother in personal significant moments. Aunt Margaret used to walk with me part of the way back from my grandmother's residence to the school of nursing. I used to turn after I had walked a block up the hill and I would see her waving furiously at me from under the street light. She would be there in her wool shirt, dress, apron, and knee socks. When she accompanied my mother years later to North Carolina for cancer treatments, she would be there holding on to my sick mother and waving until she got my attention in the same apparel except for the apron. They seem to stand out in a crowd because they were different and not part of what I wanted to embrace. Now

years later, they are with me on my mental journey on this bridge, as I try to figure what I see as important in sustaining care in my personal and professional life. I see how important they were in my life as well as how they influenced my beliefs and attitudes about caring and women's work. I am constantly working at maintaining this gender sensitive ideal. Also, my thoughts are on Florence Nightingale, the founder of modern nursing, and the early monograph, *Cassandra* that she wrote before Notes on Nursing. Langston (2001) writes of the three attributes Nightingale said were unrecognized in contemporary women in the middle of the nineteenth century. These attributes are passion, moral activity, and exercise of intellect (p. 58). I see Martin as wanting women to have passion about what they are doing while they are having opportunity to use their intellect. I struggled with these issues early in my professional life. I see these as still relevant issues that must be addressed for today's nursing students.

The middle ground holds the best potential to maintain a gender sensitive ideal about education and aspire toward passion, intellect, and moral activity or commitment in nursing. It is important for nurses to reach their full potential. Within the educational process, I see caring as the guiding force in the self-actualization of students. A caring educator assists students in valuing their personal experience. I was not able to move forward until I understood how my everyday or embedded experiences are validated by theoretical constructs. Theory supports the practical knowledge I gained from seemingly inconsequential moments. Practical or ordinary experience is needed to support theory. This forward journey requires an examination of how behavior is often influenced by the prevailing discourse. I needed to examine the multiple meanings of care I experienced directly or indirectly. In this understanding, I see how the reproductive and productive realms are equally important in my personal and professional life. In making sense of this, I have come to understand the importance of practical knowledge. I view practical knowledge as making sense of what is important to the people around me as well as bringing forth their potential. This process is what I experienced in the Analysis of Education class. It is what I now try to bring to my students.

Caring is sincere and evolves over time. It is something most individuals learn, hopefully in their family of origin. A family gives an individual a sense of relatedness. The individual's growth is nurtured through attentive care and concern. I think that if you experience attentive concern you learn how to be with people. This process is more than doing something for someone. It involves sensing when someone needs guidance or direction in a particular area. This is hard to define or quantify, but it is an essential element of human relationships. Nursing

and teaching requires a balance of caring behaviors with thoughtful inquiry. This balance requires an appreciation of difference. People are not always going to respond, behave, or perform as one expects them to do. This aspect of people makes experiences more subjective. In health care, it is important not to make the patient an object needing a treatment.

It is my responsibility to teach students technical skills. My profession sometimes catches itself up in the acquisition of technical skills. It is equally important to exhibit caring behaviors when performing a procedure. This caring stance allows you to see changes and to make astute observations about a patient or student. I personally think if this stance is lacking then the patient or student is at risk of being treated as an object. In education, it becomes important to understand why a student is not doing well in a class. Sometimes it is beyond the educator's realm. When a student does not do well in my class or turns in the wrong material, it could be entirely the student's shortcoming. However, before this conclusion is drawn, I feel a teacher needs to ask what can I do to help this student. The educator needs to work with the student until the student identifies his or her problems. In this identification process, the teacher and student should both work toward a resolution to the identified problem. An appreciation of difference enhances the caring exhibited to a patient or student and leads to understanding of his or her environment. I have several thoughts about how difference makes human situations unique.

In nursing, you often deal with people who are very sick, old, have a poor disposition, or someone you just do not like. Before a nurse can begin to meet the needs of an individual, the nurse needs to try to understand where the patient is coming from and who he or she is. It becomes important to attentively listen and offer someone some touch or form of human contact. I was looking through a copy of the American Journal of Nursing, which covered one hundred years of nursing in the United States. I found an article, "How Can You Bear to be a Nurse?" by Mallison. Mallison (2000) says patients are often old and very sick. It must be very difficult to think that your care will not make a difference. The author answers her question with the following statement:

> Wait until you have used your hands, eyes, and voice to dispel terror, to show a helpless person that his life is respected, that he has dignity. Your caring helps him to care about himself. His helplessness forces you to think about the brevity of your own life (2000, p. 39).

This caring connection is what Cassie experienced with Barry, her patient with a neurological impairment. Susie and Tonya also experienced this with Barbara, the woman with multiple sclerosis. I think this connection leads to an intuitive sense about individuals. This intuition can be learned but not necessarily taught. I believe nursing needs to talk about this therapeutic connection with patients to make it more visible. The nurse educator can guide students toward this stance through thoughtful questioning and attentive listening to the students' concerns. As I write this, I remember a John Dewey reading. Dewey says you cannot teach a student what he or she needs to know, but for them really to learn, the student must see it on his or her own terms. I used this several years ago as a starting point to change and enrich my perspectives. I started to view myself as a coach in the clinical area. This view moved me from being a content-driven teacher to being more process oriented. I question and listen to students until they arrive at an acceptable answer. I do not give the correct response, but I guide the students until they arrive at an appropriate response. Students who are unsure of their abilities respond well to this approach. The students then feel caring from the teacher and are more apt to incorporate caring in a beginning practice. I see caring as allowing one to think through nursing actions and to be able to meet what the patient needs at a particular moment. Sometimes a nurse will not know whether a difference is made, but the nurse needs to try to connect with a particular patient. I see students learning this through dialogue, role modeling, and confirmation. First, the educator must appreciate how his or her students are different from one another as well as what they bring to the learning environment. If the educator starts with this insight, he or she can avoid pre-judging students' interests and abilities. In an earlier chapter, I comment about a student who is a displaced worker. He has a true Appalachian dialect and sometimes it is very apparent that he is struggling. He tries very hard in all his endeavors. When I first encountered him, I made myself listen carefully to what he was saying. It would have been very easy to draw conclusions about him because of appearances.

It amazed me how well prepared he was when caring for his patients. Another faculty member and I were talking about how he always follows through on suggestions from his instructors. He is our student and we care about him. We want him to be successful and value his efforts. There are also students whose world or generation is not my own. Sometimes it is hard to understand what point students are trying to make. In trying to understand, I have learned there are no right or wrong ways of knowing. This approach enhances an individual student's self-esteem because the teacher is showing faith in the student and giving him or her a

sense of control. This approach is caring and enabling to a student and leads to dialogue. The dialogue between a student and teacher allows both to gain new knowledge while in new situations. Nursing students need to know more today as they deal with a changing health care environment. Tagliareni (1993) says it best when she calls on nurse educators to show up, be attentive, tell the truth, and accept what happens. I know I have to work hard on this to be effective. I see it as a method to maintain care in professional nursing education. Care is an interpersonal skill that allows one to be responsive to another. I see the process of care as involving cognition and interaction that translates into some type of behavior. A fully present teacher notices problems in students and assists the students in finding and implementing the solution. If a teacher follows through with this process, the teacher can tell the truth and accept what happens. Some students will not follow through with faculty suggestions or students make mistakes in the clinical area. Since a clinical course involves people, the teacher must be truthful. I see this process as helping students recognize the power they have within themselves to facilitate change within themselves and others. I also see this process as respecting difference in students and not expecting them to conform. I feel this is a good method to show students how to be with people because it helps establish connection. This sense of connection allows the student to value his or her experience and this increases receptivity. A nurse who values personal experience and connection will allow care to guide the use of technology. When care is used to guide technology, it becomes more human and addresses the subjective experience of the patient. A nurse who is attuned in this matter can notice subtle changes in a patient's cardiac status before the monitoring equipment does.

There are two important issues I would like to address regarding this caring connection with patients. A student learns this stance from competent teachers. I see different degrees or paths to competency in educators. I believe a nurse educator must practice to maintain passionate scholarship about the subject. This unifies theory and practice for students and makes teaching reality based. Next, I think an educator needs to value clinical learning for nursing students. A colleague spends hours the day before her students' come to the hospital to prepare for their clinical experience. I admire what the educator does because she works on being competent before the students arrive. She does this because she really cares about the experiences that her students will have. The second issue is health care organizations tend to value instrumental procedures rather than intuitive knowledge that the nurse exhibits. I think this intuition is equal in value to the technical expertise. It is not a reimbursable commodity

because it is invisible. It is invisible because we do not talk about it. I see my role as making it more visible to a student. By referring to moments when caring made a difference to a patient, I make it more visible to the student and other nurses. This process requires a continuous focus on meeting another's needs for care. This leads to the third issue related to clinical caring in nursing. This intense involvement requires nurses to care for themselves. As a predominately female profession, nurses get so involved in doing for others that they fail to care for themselves.

Caring for yourself allows the individual to nurture and refurbish the inner self. This affords one to have more energy when caring for another or patients. It vitalizes the individual nurse to "show up and be there" for patients. If this is not done, the individual lacks the heightened awareness that leads to intuitive knowing. After some time, it becomes very easy to become disillusioned with the profession. I encourage students to take time to care for themselves and do special things with their families. This permits them to be more fully present during their educational process. I think this caring for self is the exception for nurses and nursing students and not the rule of practice. Since nursing is predominately a female profession, I see females being socialized to think it is their responsibility to do everything for their families. They spend all day in class and spend several hours preparing for clinical at the hospital. Then they go home, help their children with homework, and cook meals. The students fill every minute of every day with an activity. The fact they want to enter a profession where they care intensely for patients complicates their caring for self. At the end of the day, it becomes important for someone to care about them as students and individuals. I believe it is crucial to guide them to care for themselves. This process begins by trying to understand the student's reality and then by conveying to the student that you have faith in their abilities. Then, the educator can see what events having significance to the student.

The educator can start this process with reflection on experience activities, such as keeping journals. This process allows students to see different choices, understand their experiences, perceive problems, and work toward resolving those problems. It also helps them remove bias from the experience by giving them a greater sense of personal control. Most of all, the process of reflection helps students pay closer attention to themselves. This allows them to get in touch with what they need as a person. A student may struggle with an instructor, or content within a clinical course. I think it is hard sometimes to determine if it is the instructor, the content, or both. It is hard for the instructor to admit that he or she may be the reason why a student is having a problem. I think that journal writing is an excellent method to diagnose why

a student is having a problem. The student and the instructor have to both be open to the fact that they may be changed by this process. The use of clinical journals helps a student construct and evaluate their knowledge base and learning. I see journals as a way for faculty to care more fully for students. Journals help the teacher see and appreciate when another's perceptions differ from the teacher's perceptions.

I see another pressing issue about care and nurses. It is something important but not addressed in this dissertation. Health care institutions are facing impending shortages of nurses. It is time for these institutions to care about nurses. Schedules, weekend work, and mandatory overtime makes it difficult for nurses to have both a rewarding personal life and a professional life. It becomes hard to balance natural caring and professional caring. In a way, nurses become vulnerable like their patients. I am sure I do not have all the answers. I know the nursing profession and health care institutions must work on this if they want to sustain caring practices. It should also be asked how the nursing profession would maintain caring among nurse educators.

I believe caring occurs in nursing education through student-teacher interaction. The teacher facilitates caring dialogue. The student feels caring through verbal and nonverbal communications. The verbal dialogue may include talking about feelings and attitudes, clarifying expectations, asking and explaining, and most important laughter. Students need to see the teacher as a human person. The nonverbal dialogue involves eye contact and connecting with the individual to convey value and respect. The other person should know by your nonverbal behavior that he or she is important to you. An educator may have a problem with a selected nursing student. The student does not seem well prepared in the clinical area. However, the educator knows the student has been successful in previous courses. I think you always need to be truthful with students. Sometimes it may mean telling someone they have not done well. The student needs to be encouraged to identify the problem. Instead of telling a student they were unsuccessful educators should work with each student to help identify why they are experiencing a problem. Educators should work with all students to bring forth their potential.

It is very important for nurse educators to experience caring within their educational institution. My director is a very caring person and sets the climate for the faculty and students in my program. Holly makes faculty members and students feel as if they are important to her. She has an open door policy with faculty, staff, and students and therefore is very accessible.

Our students know from the first day of class that she wants to hear what they have to say. Holly shows presence and understands the meaning behind words. She shares decision-making and creates an empowering work environment. I think she is secure in her use of power and wants her staff to reach their unique potential. Holly works to maintain her clinical competencies. She does not expect individuals to do what she would not do herself. The best thing I can say about Holly is that I want to keep working with and for her. I see her as setting the stage for a caring educational climate. Students need to learn in a caring climate because there are many challenges to caring their patients.

Nursing is practiced within a system that places emphasis on economics rather than care. It becomes important for nurses to talk about care in practice and education. I see narrative as a method to show how care is embedded in everyday practices and how nurses make sense of what we do. Narrative allows me to center on change and growth within my professional and personal life. This change or growth is seen through the experience of doing something as well as the result of some action. I see power within caring since it involves a choice. The greatest gift we can give students is to help them see the power they have within themselves. A choice to care means connection and a focus on another's needs. Caring is a way of being and requires skill. Part of the skill of caring is recognizing we cannot always care with great depth and breath. This recognition acknowledges limitations to caring and stresses how one must care for self. This process allows the nurse to be receptive to caring occasions. The capacity for receptivity allows one to see that an individual rarely has all the answers. The important aspect of this process is to work on the solution to the other person's needs. The other person may be a student or a patient. It is the process of working on a solution where caring makes the difference to the student or the patient in nursing situations. Care in nursing education is like an art form. You must practice voice to become an accomplished singer. Nurse educators must provide a caring learning environment if they want student nurses to be caring. In order to create this environment, educators must be dedicated to caring, have an understanding of its theoretical constructs, and practice caring within all aspects of life. I think this process allows one to make more visible the knowledge used in every day practical situations. Care must influence how educators relate to students and make decisions about them.

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VITA

Bernadette Marie Dragich

Degrees Earned

C.A.G.S.	May 1997	VA Polytechnic Institute and State University
M.S.N.	December 1985	West Virginia University
B.S.N.	August 1975	West Virginia University
Diploma	August 1972	Uniontown Hospital School of Nursing

Teaching Experience

Bluefield State College	
Aug 1986 - present	Med Surg Nursing, Pediatric Nursing, Pharmacology, Health
Bluefield State College	
Aug 1982 - May 1983	Medical Surgical Nursing
Forsyth Technical College	
Aug 1979 - Dec 1981	Clinical Instruction–Nursing
WVU–Parkersburg	
Aug 1975 - April 1976	Clinical Instruction–Nursing

Professional Experience

Family Nurse Practitioner at Princeton Pediatrics
1994 - present
Academic Nursing Center, Coordinator Bluefield State College
January - July 2000
Academic Nursing Center, Bluefield State College
1993 - 1999
Consultant, Regents College
1999 - 2000
Family Nurse Practitioner at Southern WV Primary Care
1990-1993
Office Nurse at East River Primary Care
1983 - 1986
Staff Nurse at North Carolina Baptist Hospital
1976 - 1981
Staff Nurse at WVU Medical Center
1972 - 1975

Professional Certifications

Clinical Specialist in Medical Surgical Nursing
Family Nurse Practitioner
Certified Red Cross Instructor in Safety and First Aid
Life Skills Training

Professional Organizations

American Nurse Association

West Virginia Nurses Association
National League for Nursing
Sigma Theta Tau
American Academy of Nurse Practitioners

Professional Studies

Award Fellowship in End-of-Life Nursing Education Consortium sponsored by the American Association of Colleges of Nursing.
June 2001, Cleveland, Ohio

Publications

"Misty Mountain Nurses." *The Bluestone Review*. April 2000
"Springfall'98" *The HeART of Nursing*
Fall 2001

Professional Presentations

"Caring Narratives of Registered Nurses." West Virginia League of Nursing Annual Meeting. Parkersburg, West Virginia
April 2000

"Caring Narratives." Research Day. Radford University
April 1999

"Update on Infant Nutrition and Feeding Practices." Partners in Perinatal Care. Twin Falls State Park
October 1998

"Voices of Caring." The National Nursing Research Conference. Charleston, West Virginia
October 1998

"Preceptors: Bridging the Gap from Theory to Practice." Eastern Kentucky University's ADN Nursing Conference. Richmond, Kentucky
September 1998

"A Care Plan for Clinical Teaching." The Sixth Annual ADN Faculty Development Conference. Dayton, Ohio
August 1998

"Clinical Journals: A Teaching-Learning Strategy." Paper presented at the 5th Annual ADN Faculty Development Day. Dayton, Ohio
August 1997

"Clinical Journals: A Teaching-Learning Strategy." Paper presented at the West Virginia League for Nursing Annual Meeting.
April 1997

Professional Creative Arts/Poster Presentations

"Spring /Fall 98" Sigma Theta Tau International Conference. San Diego, California
November 1999

"Sensory Deficits in Older Adults and the Role of the Nurse Practitioner." 2001 National Conference of the American Academy of Nurse Practitioners, Orlando, Florida
June 2001

"The Caring Narratives of Critical Care Nurses." CamCare Nursing Research Conference. The Greenbrier Resort, Lewisburg, West Virginia
November 2000

"Preceptors: Bridging the Gap From Theory to Practice." National League For Nursing. Nashville, Tennessee
September 2000 (invited)

"An Effective Listserv Enhances Associate Degree Education." Poster presented at the International Nursing Computer and Technology Conference. Orlando, Florida
April 1998

Book Reviews

Pharmacology by Lilley and Aucker (2000). Harcourt Brace

Child Nursing (proposed text material). FA Davis

Use of Herbal Therapies (proposed text). FA Davis